HOSPITALS

THE JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

VOL. 11 MARCH, 1937 NO. 3

The Community Hospital and the Next Generation

DONALD M. MORRILL, M.D., Medical Superintendent
Receiving Hospital, Detroit, Michigan

SEVERAL YEARS AGO I became gradually conscious of the inter-relation of a series of experiences, facts, and observations, each of which had profoundly impressed me as it occurred or came into the field of my consciousness. It was thrilling. I had a vision that was to transform the lives of thousands, yes millions of boys and girls, men and women. Who would not be thrilled by the consciousness of such an accomplishment? For weeks I dwelt upon the noble prospects of this vision until one day the opportunity came to present it to those who might aid me in transforming it into reality. Then came the awakening. A few simple direct questions of fact and method could not be answered, and the whole dream faded into oblivion.

The world moves on about one in spite of broken dreams, however, and gradually of late I have seen the major purpose of my vision coming into being. I believe further that I see added ways and means of hastening the accomplishment of this purpose, and therefore have the temerity to write upon this subject for publication.

Tangential Activities of Hospitals

The twentieth century thus far has been marked by tremendous expansion of hospital facilities and the rapid advance of specialization in medicine, with which we are all familiar. In these developments, however, there has been a tendency to tangential activity, which until recently has gone on quite unchecked. The medicine of 1900 has become a profession of more than twenty specialties, each tending to narrow more and more its intensive field of application. With this specialization of medical practice has come the development of special hospitals caring only for those suffering from certain types of diseases, until recently we are urged by some to believe that the general hospital can no longer safely care for maternity patients.

Parallel to this specialization in medicine has also come specialization in many collateral fields of human interest and activity, witnesses to which are the intensive campaign against tuberculosis; the International Society for Crippled Children, associations for the blind, the deaf, infant feeding societies, prenatal clinics, maternal health clinics, nursery schools, pre-school study and education groups, child guidance clinics, mental hygiene centers, cancer centers, and many more—all in addition to rapidly growing departments of public health.

Integration of Public Welfare Activities

Furthermore, the great bulk of the public expenditure of billions of dollars and untold energy in all these multitudinous activities is still directed toward the diagnosis and treatment of disease. Salvage is still the guiding motive, or at most the prevention of greater ills than those we bear. This is not said to the slightest degree in derogation of the splendid purposes and magnificent accomplishments of those agencies of human welfare we have mentioned. Rather, it is a hastily drawn picture to give us pause for thought, and realization that the time has come for integration of the best in all of these fields for the purpose, not of treatment alone, not of prevention alone, but primarily for the construction of a better, healthier, happier race. Very little has yet been done on an integrated basis toward the development of the maximum potentialities of a generation of men.

This statement fortunately is not entirely true, as naturally the constantly improving health, social, educational, and economic standards which we are witnessing tend toward improvement of each succeeding generation. Furthermore, there are isolated developments and projects having the direct constructive purpose of racial betterment.

The present national emphasis upon maternal health is of course reaching a fundamental objective. The development of the *Euthenics* course at Vassar College, in which young women receive preparatory training for marriage and the care and training of children, has had an important effect upon the whole field of education. Psychological and health services in the universities are performing an important function for the next generation. The improved standards of instruction in the biological sciences and hygiene in our public schools are rapidly bearing fruit. The Merrill-Palmer School in Detroit, Michigan, has given important emphasis to consideration of the whole child, mental, emotional, and physical, as is borne out by recent articles in *HOSPITALS* by members of its staff.

In at least one instance there has been a splendid community development under authoritative guidance, which integrates the whole field of child health from birth to adolescence. I refer to the work of Dr. A. Graeme Mitchell in Cincinnati, Ohio. There we find the agency for infant feeding, the milk fund organization, the pediatric clinics, children's hospital, convalescent home, children's research foundation centered, not in an individual, but in the department of pediatrics of the University of Cincinnati.

The above observations have led us backward through the cycle of a generation, but nothing has yet been said of the Eugenists' urge for controlled mating rather than the age old law of natural selection. We will leave this debate to the academicians, but should not overlook the practical matter of birth control, which is now receiving much attention, and which received an overwhelming expression of approval in a recent Gallup poll, observed by the writer in the Detroit News.

Role of the Hospital in the Future Program

As this article is appearing in a hospital journal, the reader is by now wondering perhaps what all this has to do with hospitals, and I would answer, a very great deal. When in 1929 I proposed a demonstration project to one of the charitable Foundations, suggesting health and educational guidance and service to a limited case load of clients covering the cycle of a generation, I was met with two very troublesome questions; one, where would one find a sufficiently stable population; and second, how would you avoid an excessive paternalism.

At that time, these questions were not answered, but as I have watched community developments, and have analyzed the facilities and services of the hospital I am administering, I believe they can now be answered. The answer is the simple statement, "in any truly general community hospital having a competent medical and administrative staff and an assembly room or amphitheatre." In fact I would go further and say that most such hospitals are now conducting a considerable part of such a project, whether or not their administrators are conscious of the fact.

Let us briefly consider the case of Mrs. Meade, whose first baby was born in your hospital last night. This morning a pediatrician on your staff examined the baby carefully, and will see it regularly while the mother and baby are in the hospital. If artificial feeding is required, he will prescribe it. If some slight abnormality should be corrected at one month or six months of age, he will advise it. When Mrs. Meade is sufficiently convalescent, she will be taken to the nursery service room and instructed in the bathing and care of her baby. In all probability she will be offered a reliable treatise on infant care, and perhaps, as has been our custom, given other health and guidance references which she may purchase if desired.

Mrs. Meade felt very much at home in the hospital, because she had been born there herself,

and had been brought back to this same hospital all through childhood whenever she had been ill. This was not often, but her family lived in an apartment where it was difficult to care for a sick child. Also, her mother believed that an ounce of caution was much better than the risk of serious illness. Each time she came to the hospital she learned something new from the doctors and nurses regarding the care of her health, or if she did not learn anew, was convinced that what her teachers had said was right.

When in her teens, and convalescent from an appendectomy, her nurse had taken her to visit a class in the nursing school. The student dietitian had shown her the kitchens and the manner of preparation of weighed diets. The intern had told her of the value of staff conferences, lectures, and daily experience in the hospital to the young doctor.

Mrs. Meade's mother always felt kindly towards the hospital since the day she called to inquire the name of a reliable obstetrician, as she had just moved to the city with her husband shortly before her baby was to be born. This obstetrician limited his practice, but as need arose in the family, the hospital referred the mother to a staff internist, who in turn advised such other specialists as were needed from time to time.

How often we see four or five doctors in the x-ray room, laboratory, or locker room, discussing the problem of the patient of one of their number from sheer professional interest, with no thought of a consultation fee. This, like our staff conferences, is education, and we operate potential educational institutions whether or not we recognize them as such. Why not carry this educational function a step further and give the public, who support and maintain our hospitals, the full benefit of our educational potentialities.

As stated above, mobilization of the facilities, personnel, and staff of any *truly* general community hospital is all that is required to make a constructive, non-paternalistic, integrated program for the development of the next generation a fact in your community. The term "general hospital" is qualified here intentionally, as I am strongly of the belief that there are certain important services still commonly lacking in our so-called general hospitals—I refer particularly to the neuro-psychiatric unit, the contagious isolation unit, and facilities for public assembly.

General Hospital as a Center of Development of the Integrated Program

The truly general hospital, then, will have facilities for the care of men, women, and children in the major fields of medicine, surgery, obstetrics, pediatrics, and in the principal specialties under these main divisions. It will have a neuro-psychiatric unit and isolation facilities for communicable disease, and will have an amphitheatre or other appropriate place of public assembly. The staff of such a hospital should include; a competent obstetrician and gynecologist, versed in the best opinions of birth control, not primarily from the point of view of contraception, but rather the view of child spacing in relation to maternal health and the encouragement of as many children as may be well born; a competent neuro-psychiatrist with sufficient practical bent to be successful in mental treatment as well as organic and functional diagnosis, and with a broad understanding of child guidance problems; a psychiatric social worker and psychologist to aid the psychiatrist in out-patient clinic work; a competent pediatrist who is in sympathy with problems of mental and emotional control of the child as well as physical management; a competent orthopaedist assisted by trained physical therapists, keenly alert to postural problems; and consultation services in the specialties of medicine and of surgery would be available.

The personnel of this general hospital would include nurse educators in the persons of the superintendent of nurses and unit supervisors. A trained nutrition worker would be available in the dietitian, and a trained housekeeper in the matron. The community supporting such a hospital would have a visiting nursing service whose cooperation could be elicited, or if not, an experienced visiting nurse could be added to the out-patient staff.

Most hospital boards of trustees attract to them those public spirited and socially minded citizens who are apt to have read broadly upon sociological subjects, and who would be competent to discuss them before groups of young men and women. Trained educators are also often found on boards of trustees, and we may take for granted in any approved hospital the availability of competent services in x-ray and clinical laboratories, intern services, and reliable records.

With such an array of specialized knowledge centered in the hospital, how natural that intelligent young parents should look to their hospital for guidance in raising their families, and in bringing their children to the highest level of development that the individual child's potentialities will permit. Mobilization of this special knowledge through the arrangement of a series of lecture, discussion, and demonstration periods, and provision of consultation hours would make these young people much more conscious of the

invaluable services at their command. In addition, the facilities of the hospital amphitheatre could be made available for neighborhood child study clubs and similar gatherings bearing upon the child and home management.

Most community hospitals have developed some type of auxiliary group of women whose voluntary service interests are centered in the hospital, and many have expanded this policy to include the younger group of women and even children's groups. A program of instruction in home care and family life could easily be initiated through the cooperation of the young married guild members and their husbands, and would, I believe, rapidly extend its influence throughout the community.

Outline for a Proposed Program

I will suggest here an outline of such a program, in the development of which I have had in mind the special talents available in my community, and have drawn slightly upon persons outside the actual hospital personnel. In each instance in which that is done, however, it is entirely possible that in other institutions the persons so drafted here might be members of the hospital's board of trustees, and if not board members—their counterparts are available in the public life of every community.

The following series of twenty meetings could be presented on the basis of one meeting each week from November through March, or with one meeting every second week, could parallel the school year, from September through June. The subjects suggested represent the writer's conception of material which should center the thoughts of young parents upon their responsibilities for the next generation, should give them aid in meeting these responsibilities, and should bring to them the realization that their community hospital is the very center of their community and family life. As yet this program is an untried vision, but we hope it may soon become a proven reality in many communities.

Lecture One

"The Family as a Factor in Social Evolution"

Speaker: Community Chest Executive

In this talk the presentation of the historical background of the family should serve to break down some mis-conceptions regarding the social value of free love and similar restless adolescent yearnings for a different social order. The "rebellion of youth" may be put down and a receptive viewpoint for later material established.

Lecture Two

"The Importance of the Family from the Viewpoint of Heredity"

Speaker: Judge of Probate

In Michigan, as in many other states, the Judge of Probate is responsible for commitment of the mentally incompetent, and is therefore in a position to be familiar with many problems of heredity. This subject could also be presented very well by the psychiatrist or pathologist. Its purpose here is not to develop the extreme viewpoint of the enthusiast, but rather to indicate conclusively that each individual enters life with certain hereditary abilities and limitations which environmental circumstances cannot exceed in development. The importance of the hereditary factor in mating should be sanely presented, pointing out the small number of very real pitfalls, but not alarming by unjustified overstatements.

Lecture Three

"The Influence of the Family upon the Coming Generation—from the Viewpoint of Environment"

Speaker: Psychologist, Psychiatric Social Worker or Psychiatrist

With the preceding presentation, this talk should establish a balanced viewpoint, and a realization that while to a limited degree one's development is determined by heredity, the degree to which the hereditary potential is utilized is to a high degree dependent upon environment. Emphasis should also be given to the difference in environment within the family for each individual in that family, children in particular.

Lecture Four

"Euthenics" or "Good Living"

Speaker: Hospital Administrator

At this point the purpose of this series should be emphasized, and the listeners made to realize that within their hospital lie the fundamental sources of guidance, protection and help which can make life more worth while for them and aid them in developing the maximum potentialities of their children.

Lecture Five

"Child Bearing and Health in Relation to the Present and the Coming Generation"

Speaker: Obstetrician

Here can be developed the trends of population, over-population in relation to death rate, natural

(Each lecture to be followed by a discussion period.)

selection tempered by intelligent understanding of eugenics, the evils of abortion, the desirability of child spacing, and the importance of competent prenatal and confinement care.

Lecture Six

"Marital Hygiene"

Speakers: Psychiatrist and Obstetrician or Gynecologist

This presentation should be a combined discussion from both the psychiatrist in relation to mental and emotional life, and the obstetrician or gynecologist from the physical viewpoint. Without turning completely Freudian or giving undue emphasis to sex problems, the importance of the psychological and physical adjustments of early married life can well be stressed to the advantage of most newly married persons. This is a delicate task requiring a special technique, which many practicing physicians find beyond their scope of expression. This meeting might well be divided so that the psychiatrist is addressing the men while the obstetrician is talking to the women. The divorce courts present ample evidence that too long we have taken for granted that nature plus the marriage ceremony will create a perfect union. The multitude of avenues of employment open to women, and a more tolerant public attitude toward divorce, contribute to the importance, from the angle of society, of the early development of harmony in the home and an increased stability of marriages.

Lecture Seven

"Pre-natal Care—Confinement and the Puerperium"

Speaker: Obstetrician

The importance of pre-natal care was touched upon in a previous subject outline, but would be dealt with here in more extensive detail. It is a subject which can scarcely be over-emphasized, and in this lecture child-bearing can be carried forward through the mechanics of confinement and the puerperium, showing more emphatically the reasons for a wholesome optimism coupled with intelligent precaution.

Lecture Eight

"Infant Care"

Speaker: Nursery Supervisor

It is not intended that the nurse will take up this subject from the pediatrician's standpoint, but rather from the point at which the pediatrician too often leaves off, the practical methods and minutia of infant care necessary to putting into effect the pediatrician's instructions. The whole daily routine of the baby should be covered, including modifications at age intervals at least throughout the first year. Emphasis should be placed upon conditions which indicate the need for calling the doctor.

Lecture Nine

"Home Nursing During Minor Illness"

Speaker: Nursing Practice Instructor

Most homes today have lost too much of the old independence and ability to give proper care to those who are mildly ill, which was universal when we were predominantly a rural people. Too often children are permitted to go to school, or if kept home, not kept in bed when they should be, because of parents' feelings of inadequacy to giving proper care to one sick in bed. As hospital people, we should not wish our hospitals filled with those who could as well be cared for at home—on the contrary, if there were universal understanding of the conditions under which hospital care is indicated, and universal means to finance that care, we would have to start at once building additional hospital beds. It is lack of understanding or lack of means which accounts for our present low national average of bed occupancy.

Lecture Ten

"First Aid"

Speaker: Industrial or Traumatic Surgeon

This is a universally important subject which requires no elaboration, but which warrants inclusion in our lecture series.

Lecture Eleven

"The Toddler and the Pre-School Child"

Speaker: Pediatrician

This discussion should be based upon preventive medical guidance, but should be given by a man with the breadth of viewpoint and understanding to cover the psychological as well as physical management of children during this important and impressionable age.

Lecture Twelve

"The Nursery School"

Speaker: Nursery School Principal

If a nursery school is not available in the community, a young matron is often found among the women's guild groups who had nursery school experience before her marriage. The advantages and limitations of the nursery school should be presented, and an effort also made to convey to the mothers some nursery school methods and viewpoints which may be utilized in the home

when such a school is not available, or is beyond the means of the parents.

Lecture Thirteen

"Preventive Medicine for the Family"

Speaker: Pathologist or Health Officer

This subject is self-explanatory, but it should also cover such matters as prophylaxis desirable before sending children to summer camps, dealing with unknown water supplies on family camping trips, protection during foreign travel, and similar problems arising under conditions differing from the normal family routine. Active, positive health should also be strongly emphasized.

Lecture Fourteen

"Mental Hygiene—The Home Factor in the Environment of the Child"

Speaker: Psychiatrist—Psychologist—or joint presentation by both of them

The growing child and the influences of parents, brothers, and sisters, and neighborhood groups should be considered here, as well as early school adjustments.

Lecture Fifteen

"The School and the Child"

Speaker: School Superintendent, Principal, or Special Teacher

This speaker should be selected with care and on the basis of breadth of vision rather than pedagogic ability.

Parent—teacher—and school group problems should be touched upon as well as general educational objectives and the importance of long range parental thinking regarding each child's education. Adult educational opportunities should also be emphasized.

Lecture Sixteen

"Feeding the Family"

Speaker: Chief Dietitian

The composition of foods, normal food requirements, comparative food costs for nutritional equivalents, and the family food budget provide material of important interest to every mother.

Lecture Seventeen

"Housekeeping Problems"

Speaker: Matron or Housekeeper

There is much that the person responsible for institutional housekeeping knows and uses daily that can be made of value to the young matron in her household management—cleaning compounds and methods, laundry principles and methods, the care of rugs and floors, the care of linens, woolens, chair coverings, are examples of the items to be covered.

Lecture Eighteen

"The Adolescent"

Speakers: Pediatrician — Psychiatrist — Psychologist

There is no more trying period of growth for parents to guide intelligently than this volatile, rapidly changing period of confused mental and emotional reactions, known as adolescence. Parental errors are frequent, often through taking superficial manifestations too seriously, and being too casual about really fundamental problems. The suggestion is therefore made that this subject be taken up in symposium fashion, bringing several viewpoints to bear upon it.

Lecture Nineteen

"Family Budgeting and Finance"

Speaker: Local Public Accountant or Banker—very possibly a member of the Board of Trustees

Many parents advise their children regarding financial matters, and many do not. In any event youth is apt to disregard such advice from parents, and to neglect safety factors in its natural buoyant optimism. Sound advice from a professional in financial matters would bear more weight with youth than any amount of family suggestion.

Lecture Twenty

"The Spiritual Life in Relation to Periods of Stress in the Family Cycle"

Speaker: Local Minister of sound spiritual opinions, who also has a broad understanding of humanity and a large capacity for sensible interpretation of life.

This discussion does not presume sectarian approach or ecclesiastical hair-splitting, but rather sound emphasis upon the higher spiritual values in life and upon the strong support these values become in the inevitable trials of life that none can escape, and least of all, those of us who assume the responsibility for bringing forth a new generation.

The variety and the pressure of daily demands upon hospital people tend to cloud our vision of the broader opportunities, responsibilities, and accomplishments of our work. In the discussion above, I have tried to point out a very vital phase of our relation to the community and to the next generation. I have tried also to show how this important relationship can be broadened and deepened in value. And in conclusion I would add that any community hospital actively carrying forward such a program as the one outlined would soon become so intrenched in the hearts and lives of its patrons that it need have no fear for ample financial support as a voluntary charitable institution.

King Edward VIII Hospital

R. E. Stevenson, M.D., Medical Superintendent
Congella, Durban, South Africa

DURING the Great War, wood and iron buildings were erected as annexes to the Addington Government Hospital on the Beach Front to house military patients repatriated from the East African Campaign. At the end of the War, these buildings were handed over to non-European patients, and for fifteen years these "temporary" quarters have been almost the sole accommodation available for the Indian and native population of Durban and its large hinterland.

The most recent census, 1936, showed the figures for the population of the City as:

European	88,000
Colored (mixed)	7,500
Indians	80,500
Natives	64,000

The City of Durban is the busiest port of the Sub-Continent and a most important industrial center. It is the natural center of hospitalization for the Coastal belts—the Sugar Cane country, and for large parts of Zululand and the Native Reserves.

Three hundred beds provided in indifferent buildings could scarcely be regarded as adequate for the needs of the non-European community. For long the native has had a rooted aversion to European medicine and hospitals and it is only in the last few years that he has been educated up to the advantage of these institutions. Latterly every hospital in Natal has become overcrowded with patients, while nearly every educated native girl has sought to become a hospital nurse. Occupied beds have, in some cases, increased five fold and out-patient attendances twenty fold in the space of five or six years.

As a direct result of this awakening, and the necessity to relieve the congestion in the Non-European wards at the Addington Government Hospital, the Natal Provincial Government decided to build a new hospital, solely for non-Europeans.*

Europeans

The site selected is at Congella at the head of Durban Bay and adjoins the Municipal Infectious Diseases Hospital. This site, belonging to the Corporation of Durban, was donated by them to the Provincial Authorities for the purpose of erecting the new hospital.

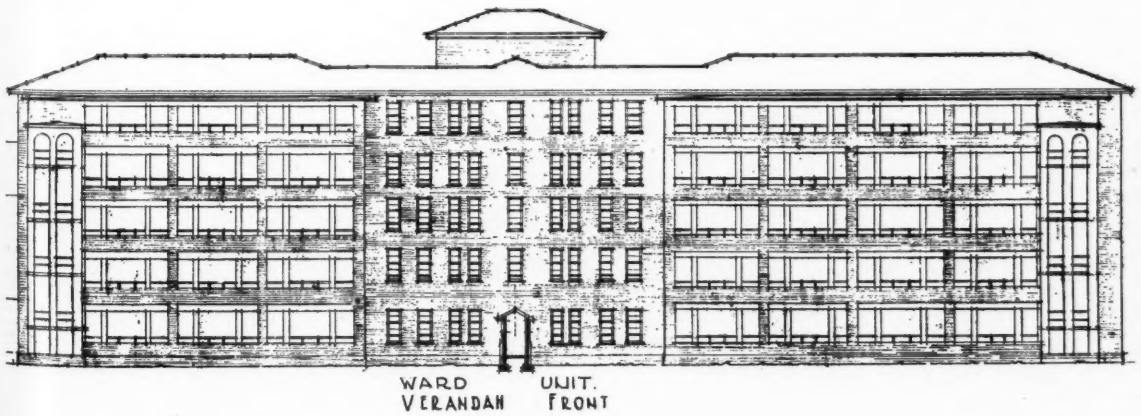
The greatest enthusiasm is manifested by non-Europeans in Natal and Zululand for this new Institution, which so definitely marks a new era in hospitalization for this section of the community. Zulu Chiefs with their Indunas and Head Men travelled hundreds of miles to attend the opening ceremony.

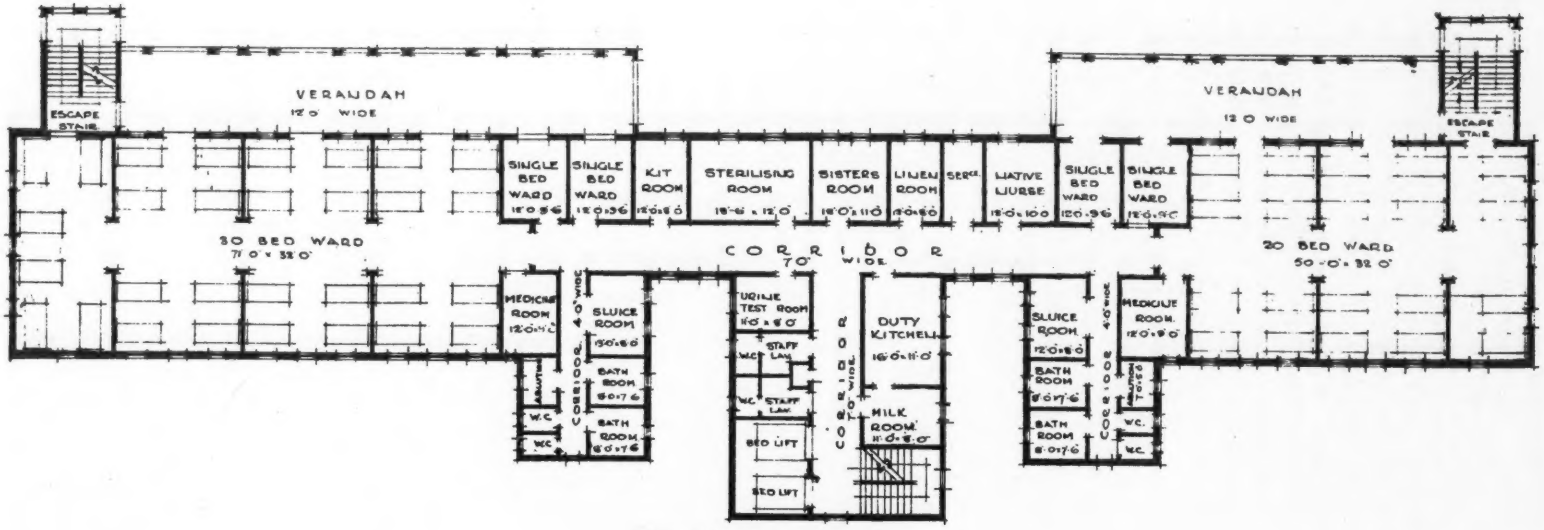
From the point of view of accessibility to the industrial, railway and dock areas of the city, the hospital is very well sited, and the grounds are sufficiently extensive for indefinite expansion. The buildings already erected are part only of the contemplated scheme.

European and colored cases will continue to be served by Addington Hospital, while the King Edward VIII Hospital will take native and Indian patients only.

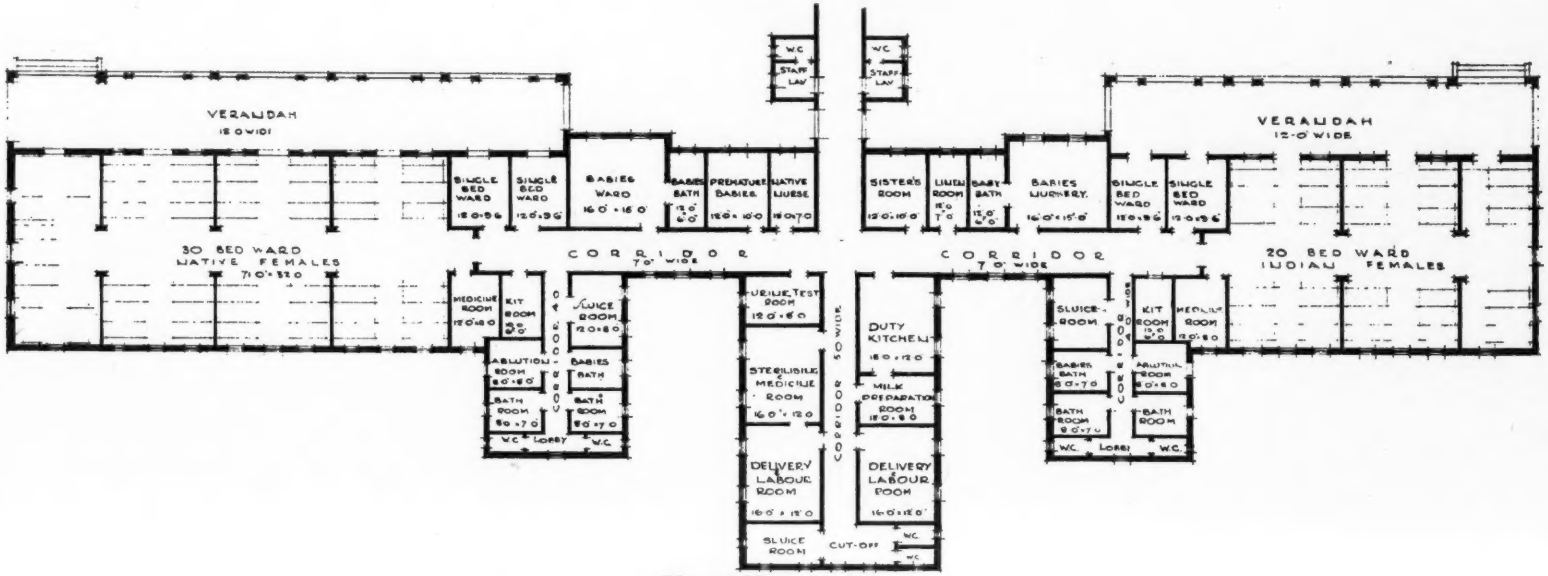
Before transferring patients, the new hospital was completed in almost every detail, but owing

*Messrs. Powers & Powers, F/A.R.I.B.A., M/M.I.A., Chartered Architects.





Plan of Typical Ward Floor



Plan of Maternity Unit

to the extreme "rawness" of the Zulu nurse probationers, the change over was very gradual. Chronic and simple—from the nursing point of view—cases were first admitted. Later came the maternity department and lastly the out-patient and casualty departments.

Unfortunately there is a great dearth of trained nurses in South Africa. There are no trained Indian girls, and only a negligible quantity of native nurses who have been trained by certain Mission Station Hospitals of limited scope. Nurses, therefore, have had to be imported from England, and it is found necessary to have a numerically very strong staff of trained nurses to supervise the work of the non-European students who are apt to be unreliable and only to be trusted under the strictest surveillance and discipline.

Problems of Construction

The grounds of the hospital are very extensive and remote from any thickly inhabited area. In front lies a large railway reserve—at the moment a reedy marsh—and beyond is the railway line to the interior and the South Coast Main road. The graving dock, wharves, and a number of factories and mills are in the near vicinity.

The great problem which confronted the architects was to comply with the customs of the various tribes of the Bantu race on the one hand, and the caste distinctions of the Indian community on the other. Although the two races could conveniently be accommodated in separate blocks of buildings, the questions of foods and diets for the in-patients, which in certain cases have to be prepared in a different manner and in separate kitchens according to the tribal and religious customs of the patients, presented no little problem in planning and equipment.

The nature of the site also presented structural problems. The soil is very sandy and lies on a bed of clay, sloping down the Congella Ridge to the marshy ground (partly reclaimed) at the head of the Durban Bay. A great deal of sub-soil water consequently drains down the site, and a great quantity of seepage was encountered at numerous points on the site which necessitated laying a comprehensive system of sub-soil draining, in order to prevent the sand under the foundations being carried away by the flow of the seepage water.

This lack of uniformity in the site required the foundations of the various buildings to be specially designed and constructed in reinforced concrete to distribute the superimposed load according to the carrying capacity of the ground below.

In these latitudes, and having regard to the prevailing winds, this lay out presents the maximum frontage to the cool sea breezes, but does not avoid entirely the direct rays of the scorching sub-tropical sun. The importance of getting every breath of wind to counteract the great humidity has been considered of greater importance. It may be necessary to shade certain windows during the summer months, but this is not anticipated. Unfortunately the possibility of arranging for the air conditioning of the building was quite impracticable from the point of view of expense.

Owing to the strict insistence for segregation, the native and Indian blocks are widely separated. The casualty and out-patient departments, each with its separate entrances for the two races, are centrally disposed, together with the admitting departments and administrative offices. Behind these departments are the theatre block and the x-ray and massage departments. Segregation has not been carried out to the extent of providing for a duplication of these departments.

The midwifery department lies to the south side and here again separate wards and labour rooms are provided for the two races.

The central block is linked up with the pavilions by paved covered ways—open on the leeward side. The main kitchen is on the ground floor of the central block. There is attached a special vegetarian kitchen because, as has been said, in addition to the necessity for segregation between Indians and natives, the Indians themselves are divided in various sects, some of whom must have certain diet which is untouchable by others.

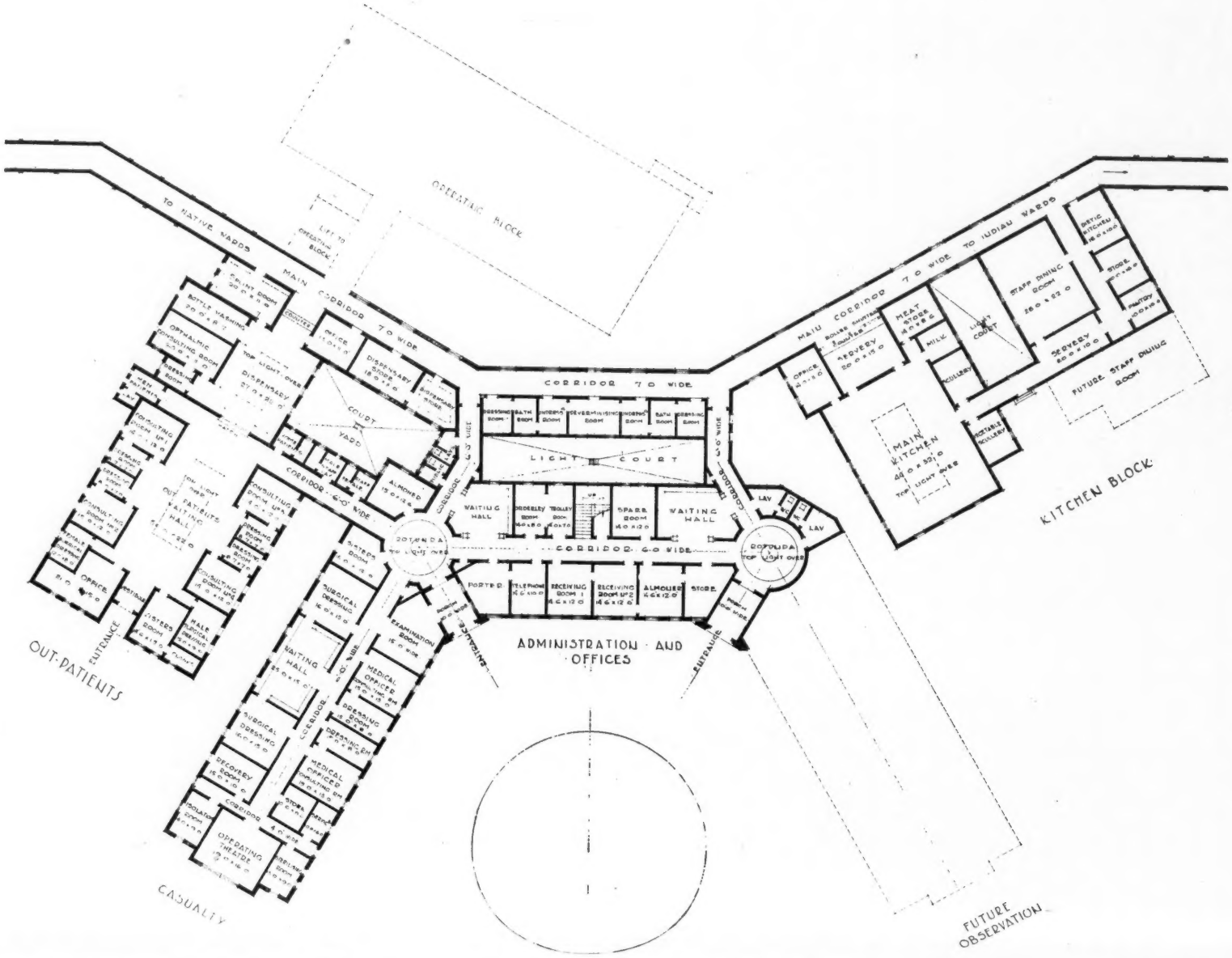
Layout

The layout plan gives a comprehensive idea of the completed scheme. The reasons for the placing of the various units in the positions as shown may be of interest.

It was estimated that the ratio of native to Indian patients would be about 5 to 3. The site roughly is the shape of the letter "L," and the architects immediately realized that the ground included in the long arm of the letter "L" would be more suitable for the native patients, leaving the shorter arm for the lesser number of Indian patients.

The layout plan does not show the contours of the ground, which, generally speaking, has a uniform rise from Congella Road on the lower level to the higher ground in the vicinity of the five-story native ward unit. The advantages to be obtained by the rapid rise in the ground was realized by the architects when designing the buildings. It enabled them to plan the single-story buildings fronting the main road on the east, and to locate the multi-story ward blocks on the higher level in the west. By so doing, the

Plan of Maternity Unit


TO NATIVE WARDS
MAIN CORRIDOR 7'0 WIDE
OPERATING BLOCK
LIFT TO OPERATING BLOCK
PAINT SHOP
BOTTLE WASHING
OPHTHALMIC CONSULTING ROOM
DISPENSARY
TOP LIGHT OVER
DISPENSARY
PRICE
DISPENSARY
COURT YARD
CORRIDOR 7'0 WIDE
CORRIDOR 6'0 WIDE
ALMORIES
CONSULTING ROOM
CONSULTING ROOM
CONSULTING ROOM
WOMEN'S WAITING HALL
MEN'S WAITING HALL
OUT-PATIENTS WAITING HALL
SISTER'S ROOM
MALE DISPENSER
CONSULTING ROOM
CONSULTING ROOM
OFFICE
ENTRANCE
OUT-PATIENTS
WAITING HALL
SURGICAL DRESSING
SURGICAL DRESSING
RECOVERY ROOM
ANAESTHETIC
OPERATING THEATRE
CASUALTY
EXAMINATION ROOM
MEDICAL OFFICER
MEDICAL OFFICER
DRESSING ROOM
MEDICAL OFFICER
STORE
CORRIDOR
ROTUNDA
CORRIDOR 6'0 WIDE
LIGHT COURT
DRESSING ROOM
BATH ROOM
NURSES' ROOM
CONVALESCENT DRESSING ROOM
BATH ROOM
DRESSING ROOM
WAITING HALL
ORDERLY ROOM
TROLLEY BOX
SPARE ROOM
WAITING HALL
PORTER
TELEPHONE
RECEIVING ROOM I
RECEIVING ROOM II
ALMORIES
STORE
ENTRANCE
ADMINISTRATION AND OFFICES
ROTUNDA
TOP LIGHT OVER
LAV
LAV
MAIN KITCHEN
TOP LIGHT OVER
OFFICE
RECOVERY
MEAT STORE
MILK
SCULLERY
LIGHT COURT
STAFF DINING ROOM
RECOVERY
POTATOES SCULLERY
DIETIC KITCHEN
STORE
PANTRY
FUTURE STAFF DINING ROOM
KITCHEN BLOCK
FUTURE OBSERVATION

buildings were orientated to enable the early morning and midday sun to penetrate all wards and patients' rooms, leaving the lavatory annexes and service rooms to be planned conveniently in the less sunlit aspects.

No direct sun rays penetrate the operating theatres which face due south. The theatres are, of course, equipped with the latest shadowless lamps and natural lighting is considered of minor importance.

Receiving and Administration Block

It is in this block that actual segregation of the races commences, the natives entering through the left-hand entrance and the Indians through the entrance on the right-hand side of the administration offices.

A feature is the de-verminizing rooms situated in this section. The patient enters a change room in which he leaves his clothes to be sterilized and pressed while he passes on to a bathroom and changes into hospital clothing.

The casualty department is equipped with special operating theatres and a waiting hall, and rooms for surgical dressings and for treatment of minor accident cases.

Adjoining the operating theatre in this department are recovery rooms and observation wards for the temporary accommodation of patients.

Dispensary

The dispensary is centrally situated. It serves the wards from a small lobby off the main corridor, and the out-patient department through a hatch and over a counter at the far end of the waiting hall.

Out-Patients

The out-patients department consists of a large waiting hall with doctors' consulting rooms and patients' dressing rooms en suite. Rooms are set aside for the various specialties, including a dental surgery.

Adjoining the entrance is the general office and information bureau and Sisters' room.

The Operating Theatres

The operating theatre block, which is not as yet completed, consists at present of four operating theatres; two are used for general work, a third is used exclusively for ear, eye, nose, and throat operations, and the fourth for orthopaedic surgery.

A suite of rest rooms and change rooms is situated on this floor, as are also the necessary sluice and utility rooms, work rooms, and instrument room with steam sterilizers. The ground floor of this block is set aside for the use of the x-ray and physio and electro therapy departments.

Kitchen Department

The kitchen section caters for the whole institution, patients and non-European staff.

Insofar as the serving is concerned, all diets are prepared in the main kitchen and dispatched to the ward kitchen attached to each ward unit in insulated trolleys. The ward kitchens are situated in a central position, in the main corridor near the lifts on each floor of the ward blocks. It will be obvious that a central service was entirely out of the question, not only on account of the scattered buildings but because of the enormous variety of diets to be prepared.

The types of food acceptable to the natives are beef stews, porridge (made of maize and kaffir corn) and vegetables. Bread is not a natural food for them but is highly popular. Milk foods, raw milk, and fish are cordially hated. The most popular vegetables are potatoes, stamped mealies, broad beans, cow peas, pumpkins, and greens.

Obviously the most necessary cooking appliance for this type of diet is the steam jacketed pan. Of these there are twelve, of capacities ranging from 20 to 60 gallons.

For the Indians, skilled Indian chefs are necessary to prepare their numerous fish, mutton, and vegetable curries, and highly spiced dishes. A special vegetarian diet, presided over by a special chef and which no alien may prepare, is also provided.

In addition to the pans referred to, there is a large "Esse" slow combustion range, a steam roasting oven, and an electric baking oven. There are, of course, the usual food mixers, potato peelers, etc.

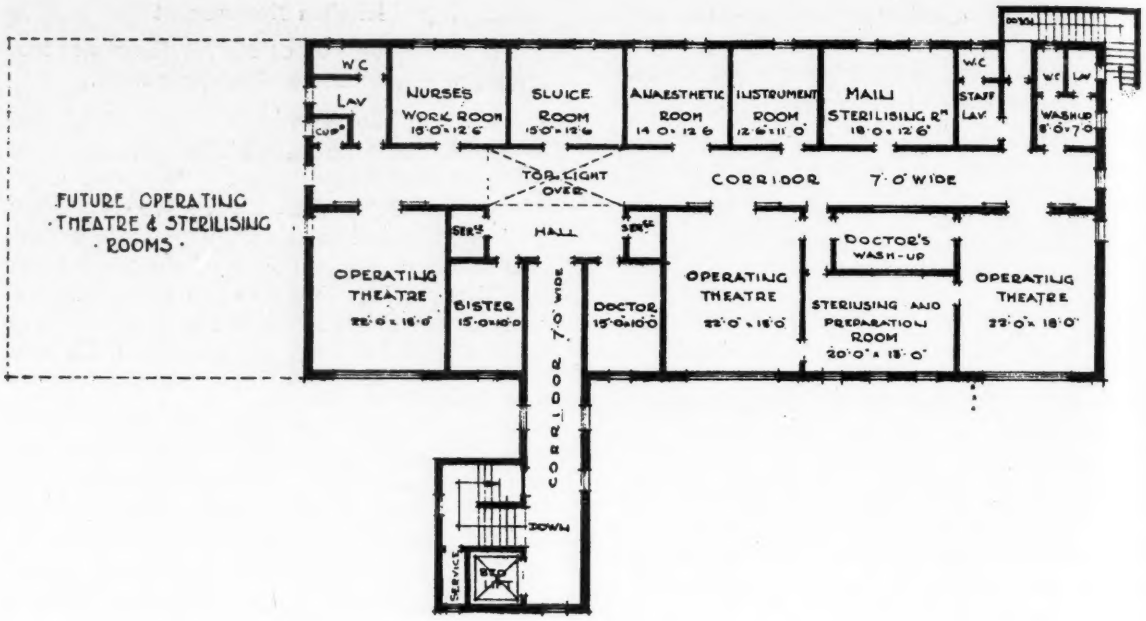
The Wards

Each floor has a 20-bed and a 30-bed ward together with four single bed wards and private rooms on each floor. The wide verandahs hold 20 to 30 beds and in these temperate climes may be occupied by almost any type of case.

The general wards are partitioned with low screens into bays, each bay accommodating four beds. The provision of such semi-privacy is not much appreciated by native patients but is popular with the medical and nursing staff making for the maximum of flexibility.

Linen rooms, sewing rooms, and service rooms are provided on each floor, and the various blocks which are allocated to medical and surgical cases of both sexes.

Children's wards with convalescent and play rooms are on the ground floor. Bed and passenger elevators are provided for each ward block.



PLAN OF OPERATING THEATRE

Maternity Unit

This block provides accommodation for about fifty patients and permits of the necessary segregation of Indians from natives.

The obstetrical rooms are accoustically treated throughout. A special block, completely self contained, is provided for suspect and septic cases.

Medical Officers' Residence

The medical superintendent's residence is not on the hospital site but lies near the European Nurses' Home on Umbilo Road, some 400 yards distant from the administrative block.

The assistant superintendent and interns are provided with quarters as shown on the site plan. For interns there are eight single rooms for juniors and three suites for seniors.

Nurses' Quarters

There are no European nurses in training. The trained European staff is accommodated in the Home already mentioned. Each nurse has a single room with built-in furniture and with hot and cold water. There are the usual dining rooms, recreation rooms, etc. A feature is the wide balconies and open courtyards which are much appreciated in a climate such as that of Durban.

Tennis courts and a swimming pool are being constructed for the European staff.

Non-European nurses are housed in the incorrectly Indians Quarters on the site plan. It will be seen that the rooms are arranged round a hollow square. Two nurses share a room. There is a sitting room and a library, but meals are taken in a dining room adjoining the kitchen in the main building.

These nurses, as has already been mentioned, require the closest possible surveillance and while restrictions for the Europen staff off duty are conspicuously absent, control of the non-European staff must be of a castiron rigidity both on and off duty.

The hollow square design of their quarters with a single doorway ensures that a watchful eye can be kept on their comings and goings.

Native Compound

The Compound consists of dormitories, kitchens, and eating and recreation rooms for the domestic and grounds staff. This staff is comprised mainly of "raw" Zulus—males and females. The Indian staff does not live on the premises.

Steam Services and Boiler House

The hospital is served from a central boiler plant, fitted with all modern devices for their free and easy handling and reduction of staff maintenance. Steam is generated and delivered to calorifiers in the various units.

The incinerator adjoins the boiler house. As yet no disinfector has been installed—mattresses, etc., are, for the time being, sent to the sterilizing plant of the adjacent Corporation Isolation Hos-

pital; a most unsatisfactory arrangement to be ended as soon as possible.

Construction of Buildings

The construction of buildings varies for the different type of unit.

We have, as the plans will show, a series of single-story, two-story and multi-story units.

The single-story and two-story buildings are naturally constructed of 9″ solid brickwork, the brickwork being faced and struck-jointed externally with smooth plaster walls internally.

The multi-story buildings are reinforced concrete framed structures, faced externally with pointed brickwork. The suspended floors are constructed of a series of reinforced concrete ribs and beams with hollow tiled slabs, firstly to reduce as far as possible the load on the foundations, and secondly to obviate sound penetration from one floor to another.

Where the question of great economy in construction had to be considered, the hollow tile system of floors commended itself to the architects, and is fully justified in its adoption.

The ventilation of the operating theatres and extraction of steam from the sterilizing rooms is effected by means of ducts with silent electric fans. This is recognized as being a poor alternative to a proper system of air conditioning which funds absolutely forbade.

The concrete floors are laid with a floor covering of the Malthoid Company's products. Dados in the open corridors are of faced brick; in the wards and passages of green granolithic.

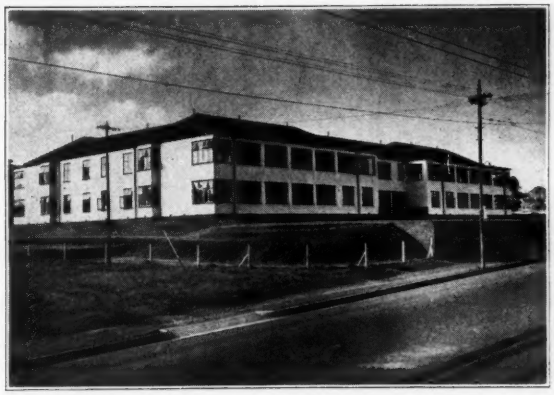
Windows are of the tilting type. Electric fittings are, for the most part, flush with ceiling or wall. Wireless is not provided—nor would the local programmes be appreciated by natives or Indians.

Patients and Nurses

It has been said that all the trained nursing staff is European. In training are native girls of various tribes—Zulus, Basutos, Fingos and Xosas—all speaking English but each tribe having different home languages, customs, and outlook.

A few Indians are also in training. The standard of education of Indians, especially females, is lamentable. Child marriage is common and prejudice keeps the numbers of female scholars to a very low standard.

It is interesting to hear many educational authorities say unhesitatingly that, as a general rule, the native will far outstrip the Indian in theory and in practice.



Nurses' Home

As far as the patients are concerned the types are legion. There are many different tribes of the Bantu—Zulus predominating in Natal. Then there are the educated, usually mission, natives and the "raw" natives from the kraal—fine specimens these latter, little removed from savagery, who often despise their more advanced brothers.

The Zulu is often very clever with his hands and convalescents are encouraged to make furniture and walking sticks out of local hard woods. One Zulu—most skilled in wood carving—is employed to assist and encourage the patients in this type of work—also in such things as mat-making, pottery, carving in wood, bone, or horn.

To complete the Babel the various Indian castes, Moslems, Hindoos, Christians, etc., speak different languages and have widely divergent customs.

It is only possible to give a brief description of this institution, but it is felt that the foregoing, illustrated with the accompanying plans, will convey some conception of this very comprehensive scheme, which, owing to the widely varying type of patient it has to serve, presents a problem somewhat out of the ordinary, and of which there are very few examples in existence.

It is felt that in countries such as the Union of South Africa where races are so many and so mixed, there is no doubt that the development of this class of institution will claim very special study on the part of hospital Architects and Administrators.

The King Edward VIII Hospital marks undoubtedly a very great advance in non-European hospitalization and it is realized that much may require modification when the remaining wards and departments are built.

The Social Security Act, the Doctor and the Hospital

THOMAS K. LEWIS, M.D., Chairman
Medical Practice Committee, Medical Society of New Jersey, Camden, New Jersey

THE SOCIAL SECURITY ACT may be divided into two portions; the first, providing special care, through Federal funds, for various classes of unemployable indigents; and the second, providing against old age and unemployment in the future for the employed.

The first portion which allocates to the various states money grants for special services to the blind, to crippled children, to orphans, for Maternal and Child Welfare, for extension of public health activities, etc., has already been in operation for six months or more. In the application of the provisions of this Act our State Legislators have turned over to the State Medical Society, in conjunction with the State Department of Health, supervision in all fields where medical service is implicated. In the use of these Federal funds the State Society has held constantly in mind two basic considerations. (1) The best service to the unemployables involved and (2) protection and assistance to the practitioner of medicine.

Our Tested and Time Proven Institutions Are to Be Preserved

With the first principle in mind we have held unswervingly, often with considerable opposition by Federal authorities, to the proposition that no tested and time proven institution already in operation within our state should be disrupted or distorted. As an example of this we point with pride to our Crippled Children's Commission which stands out, preeminently, as the finest service of the sort in the whole nation and which has served as a pattern for the organization of similar setups in a large number of our sister states. We have made certain that the use of Federal funds for crippled children shall further, but in no way detract from, the efficiency of present operation. The gentlemen of this Commission, mostly lay persons, boast of the fact, and with justice, that no crippled child of the under privileged class within our state need grow into adult life without adequate medical service and supervision.

Family Doctor Is Essential to the Needs of Our People.

In consideration of the second principle, protection of and assistance to the general practitioner, we point to the activities under the headings of Public Health and Maternal and Child Welfare. Our stubborn battle for this principle arises from firm conviction in and concurrence with the statement of the leading minority report of the Committee on the Cost of Medical Care that the family doctor is the cornerstone of the whole structure of medical service in America and is fundamentally essential to the peculiar needs of our people. In any discussion of economics one must keep clearly in mind the fact that the great mass in America is composed of middle class persons, whereas, in Europe, the great mass is made up of peasants who, in habits and in mode of thought, are little above the state of serfdom.

Under Public Health supervision there will be further support of the Public Health Hour plan of Dr. Stanley Nichols, which as you probably know has been instituted for the purpose of stimulating greater interest in preventive medicine on the part of the family doctor and making such service locally and readily accessible to all kinds and all classes. Through this plan the doctor can afford to render such service free or for a very low fee.

In handling the special service for Maternal and Child Welfare the Federal authorities were strongly in favor of full time social workers and obstetricians to tour the State and attempt to teach doctors and patients. The State Medical Society objected to this proposition on the grounds that it would not reach the spots where help was most needed; and that the caliber of the obstetrician who would give up private practice for a not too liberally paid position of uncertain future would, to say the least, be questionable. The indigents are receiving fairly satisfactory attention through our hospitals. The greater need at the moment is for support of the doctor in caring for the maternity case in the low wage group, where wretched nursing care is the rule, where low pay makes pre-natal and post-natal care burdensome and where monetary considerations preclude consultations in difficult cases, often with disastrous results. Therefore to as-

sist both physician and patient the following services are being provided through Social Security funds:

1. Lecture courses in obstetrics for the general practitioner by competent specialists.
2. Part time field physicians of recognized ability, whose duty it is to visit physicians practicing private home obstetrics and not only explain the services available but to urge attendance to lectures and to outline the rules which have been established for the purpose of reducing maternal and infant mortality.
3. The establishment of pre-natal clinics where the low pay patients can receive the proper attention, if the attending physician so wishes. These to be established particularly in the rural and more backward areas.
4. Through the nursing organization a special service for the delivery, for which the nurse is paid a special fee of Social Security money.
5. Consultation service, whereby a specialist may be called with no cost to the low wage family.

Possibility of Compulsory Sickness Insurance

At the moment, the second portion of the Social Security Act does not intimately concern us, except for the fact that up to date no one has been willing to assume the responsibility of deciding whether or not hospital employees are subject to the provisions of the Act. However, it is quite possible that in the not distant future compulsory sickness insurance will be supplemented. Labor and certain socialistic forces are bent upon such a programme and in spite of the fact that the President has expressed his disapproval, it is not unlikely that a sickness insurance amendment will be appended to the existing act.

Importance of Team Work

Should this happen it is of utmost importance that all branches of the healing art and all institutions connected with the practice of medicine unite in a spirit of team work and strive for the best interests of the American People. Special interest should be subjugated to the greater interest of the whole. Bureaus, departments, and institutions will be and have been much attracted by this plan because they deal with the practice of medicine as a mass problem. Hospitals, surgeons, and other specialists will undoubtedly be the gainers by the adoption of compulsory sickness insurance because there will be some financial return for much of the work that is now being given as a charity. However, the general practitioner will have his income immeasurably reduced and his work tremendously increased.

In considering this problem please bear in mind the fact that the medical service rendered in hospitals, important as it is, after all represents less than one per cent of the medical care received by the American public. (I refer you to the data furnished in the report of the Committee on the Cost of Medical Care which is summed up as follows: two per cent of the population is ill at a given time, fifty per cent of this illness is very minor and only five per cent of the two per cent illness is catastrophic.)

It is vastly more important to keep well than it is to receive the highest grade of medical care when seized with some hopelessly incurable disease. A prompt diagnosis of an acute appendicitis plus a mediocre surgeon is much to be preferred to a tardy trip to the hospital plus perfect equipment and the most illustrious surgeon. Without an early diagnosis of cancer of the cervix radium and surgical care of the best is of no avail. Proper treatment of the first attack of rheumatic fever and endocarditis, with careful supervision of the activities and training of the growing child with cardiac disease is the important factor, not the finest care in an institution when premature cardiac breakdown from irreparable damage has appeared. Whether this nation keeps well, whether morbidity and mortality rates are lowered and whether we can breed a hardier race rests not with institutions but with the efficiency and integrity of the general practitioner, the family doctor. It is for this reason that one of the chief efforts of organized medicine in recent years has been to reestablish that important institution, the Family Doctor, which has been rapidly vanishing, particularly in the metropolitan districts. It is for this reason that we desire, not greater concentration of medical service but rather a greater diffusion of that service.

The Family Physician in American Life

I wonder how many of you assembled here, largely concerned with the operation and management of hospitals, are aware of the part played by the family physician in every day American life. A large percentage of the patients he treats are not suffering from classic disease but are complaining of symptoms, mental and physical, which have their origin in socio-economic imbalance, such individuals need moral support, sympathetic advice and perhaps some medication to

enable them to carry on with the obligations of life in the face of insuperable difficulties. The activities of the family doctor are legion. He must be all things to all people. He is a father confessor. He must often arbitrate marital misunderstandings. He is consulted for behavior problems of children. He is consulted about educational problems. He is called upon to help in saving a home or in sending a boy to college. I could tell you innumerable tales gleaned from twenty some years in practice about the deeds of the family doctors of my community that would seem like the ravings of an opium smoker. They have done everything from washing babies and changing diapers to chopping wood and washing dishes when the need arises. You will probably be thinking that all doctors are not of this breed. Almost every family has its black sheep and I suspect that every profession has its misfits. Those of us who were involved in the recent Emergency Relief experiment are well aware of the fact that in our ranks there are some chiselers and there is some dishonesty but I emerged from my duties on the E. R. A. coordinating committee with a very high opinion of the other 98 per cent of medical men of my county, and that, I am positive, is the consensus of opinion on a state wide basis of those similarly placed. The family that puts itself in the hands of right sort of family physician, generally speaking, can be assured of getting the best kind of medical service available in that community, whether he be a full pay, part pay or charity patient. The loyal use of such a family physician, carefully selected, is the best form of sickness insurance the low income family can possibly have. For the average physician, looking back over a number of years during which a family has been the source of steady income (twenty, thirty, or forty dollars per year) is not particularly disturbed when he is called upon to treat a case of serious illness with small or delayed monetary returns. This leaves only surgical catastrophes to be covered and these can be met by a combination of hospitalization insurance and a Medical-Dental Bureau such as exists here in Newark and in several other New Jersey cities.

In concluding I would stress this one point. If, in the months to come, we are called upon to participate in any form of socialization of medicine, for the best interest of all concerned let protection of the general practitioner be the lode stone toward which our united efforts should be directed.

Mortality Rate of the United States in 1936

Director William L. Austin, of the Bureau of the Census, reports that the actual number of deaths in the 86 reporting cities in 1936 was 458,754, this as compared to the 427,736 deaths occurring in the same cities in 1935, a percentage increase of 0.9 in 1936 over 1935.

The mortality figures for 1936 are unusual in several respects. Deaths reported during February, March, and April were considerably greater than during the corresponding months of 1935. The greatest increase in deaths occurred in mid-July when the widespread heat wave sent the death rate up to 17.0. In addition to these two periods of excess mortality there was a sharp increase in the last week of 1936. The reports for this last week of 1936 show the first evidence of the general increase in deaths from pneumonia and influenza.

The rates are computed on the basis of a complete calendar year. The total deaths, death rates, and infant mortality figures for 1936 are by the Bureau of Census tabulated together with corresponding data for 1935. In the interpretation of rates, certain considerations must not be overlooked. An appreciable proportion of the deaths recorded in various cities are those of non-residents of these cities. Furthermore, there are differences in the sex, age, and racial composition of the population of cities.

Since the 1936 death rate is generally increased, there are almost no cities which show an appreciable reduction in their local rates. The greatest increases are for Evansville, Indiana; Kansas City, Kansas; New Orleans, Louisiana, and St. Louis, Missouri.

Among the cities having a death rate considerably lower than the total for 86 cities are: South Bend, Indiana; Yonkers, New York; Flint, Michigan, and Akron, Ohio.

The highest rates are in Nashville, Tennessee; Washington, D. C.; New Orleans, Louisiana; and Memphis, Tennessee. In most of these cities the high proportion of Negro population contributes to the large death rate.

The 1936 provisional infant mortality rate for the total 86 cities was 51 per 1,000 live births. This rate may be compared with the final mortality rate of 54 for 1935.

Prevention and Control of Outbreaks of Bacillary Dysentery

JOSEPH FELSEN, M.D., Director of Laboratories and Research
The Bronx Hospital, New York City

BACILLARY DYSENTERY, both as an institutional disease and in epidemic form, was known to the ancients. Its persistence through the ages is mute evidence of the flaws in our methods of disease control since bacillary dysentery is an entirely preventable disease. The English medical reports of the nineteenth century are replete with accounts of institutional outbreaks which were made the subject of investigation by a special medical commission. Gemmel, Sir Samuel Wilks (1875)[1] and Hale White (1888)[2] gave excellent clinical pictures of the disease. In 1902 Vedder and Duval[3] proved that epidemics of dysentery occurring in American institutions were caused by B. dysenteriae. In 1904 Eyre[4] demonstrated that the epidemics occurring in English institutions were caused by B. dysenteriae. Between the years 1901-1904, 1155 cases occurred in the London county asylums, 266 of them being fatal. Among military forces, major epidemics have occurred in every campaign from the Crimean War of 1854 to the Italo-Ethiopian conflict of 1936. Major and minor outbreaks are constantly seen throughout the world in civilized communities. The Jersey City epidemic of 1934 was antedated by many sporadic cases of bacillary dysentery for at least three years, as proved by examination of hospital records in that city.[5-22] In New York City during 1935 there were 559 reported cases of acute bacillary dysentery as against 349 of typhoid and paratyphoid for the same period. Hospital outbreaks are occurring with alarming frequency. In other words, in spite of our presumed highly developed system of modern hygiene and sanitation the disease has persisted. Indeed, there is evidence pointing to a steadily increasing incidence of bacillary dysentery in the United States. Defects in our public health system, greater and cheaper travel facilities and the appearance of dysentery in hitherto unrecognized and bizarre forms are the chief factors responsible for the increasing frequency. Bacillary dysentery is an excellent example of disease adaptation to changed environment. Formerly indigenous to the tropics, it is now seen in the north temperate and even in the arctic zones. Hospital outbreaks occur in winter as well as in summer, one of Sonne-Duval dysentery being in progress at the time of this writing in New York City. Once a disease with an unmistakable clinical picture it has now taken on misleading and abortive features. It is concerning these that we shall now speak since hospital and institutional outbreaks are frequently the direct result of non-recognition of the atypical cases.

Role of the Physician

(a) *Recognition of the new and atypical forms of acute and chronic bacillary dysentery by the clinician.* In recent reports eight new types of acute bacillary dysentery have been described.[5, 6, 9, 12, 13, 20] The Sonne-Duval type occurs chiefly in children, but is being seen more frequently in adults than is generally appreciated. A hospital outbreak in 1933[5] was traced to a child who had been operated upon for appendicitis eight weeks previous. This child had really been suffering from the atypical form of appendicular type of dysentery which we were just beginning to recognize for the first time. Examination of the hospital records revealed the continuous links of contact infection in the other children on the ward, forming a chain of irrefutable evidence as to the cause of the outbreak. The Sonne-Duval type of dysentery is often ushered in with misleading upper respiratory symptoms. During the Flexner outbreak in Jersey City[6] we called attention to the meningitic, appendicular, asymptomatic, afebrile and constipated types. In subsequent communications the agranulocytoid and pneumonic forms of the disease were described. We have seen numerous examples of these bizarre types in other hospital outbreaks and refer to them principally because *the physician must first recognize the disease* before he can cope with it. The earlier the diagnosis is established the less is the likelihood of further spread of the disease.

(b) *Centralization of responsibility is essential for the control of dysentery outbreaks.* There should be an Attending Epidemiologist on the staff of every hospital. He should be a voting member of the medical board and have complete charge of all hospital outbreaks (e. g. dysentery,

impetigo, erysipelas, etc.). The choice of such an individual should rest on his ability, training, and interest in epidemiological work. Special education in public health methods is desirable, but hardly attainable, in most hospitals. A member of the clinical staff or the director of laboratories may be chosen, particularly the latter if he has had a thorough clinical training. My experience in recent years is that upon the occasion of an outbreak the average hospital administration flounders about, shifting of responsibility occurs and nothing effective is accomplished. With centralization, the matter is automatically taken in hand by one individual, who immediately presents a concrete plan and follows it through to completion. He marshals his forces, makes prompt and full use of all hospital facilities and cuts all red tape to accomplish his purpose. Organization and military-like discipline are essential for the prompt termination of outbreaks. Procrastination and half-way measures invariably end in defeat. Once demonstrated, this set-up generally receives the blessing and unqualified support of the medical, nursing, and administrative staffs, for it avoids unexpected complications or deaths in patients hospitalized for other illnesses and may prevent closing of a ward of the institution. Moreover, it avoids the ever present tendency to "cover-up" or minimize the danger of an outbreak and the embarrassment of having an outsider step in to terminate it. These observations are the result of actual experience in this work in many hospitals. With a little care and forethought the entire situation could have been adequately handled in most instances by the hospital staffs. The economic and legal implications will be discussed later.

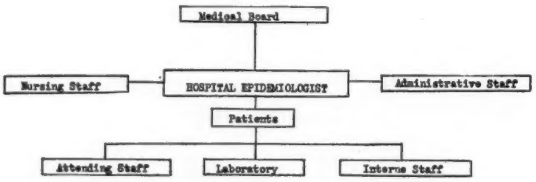


Illustration 1. Centralized control in an outbreak of bacillary dysentery

(c) *Isolation and release of dysentery patients or suspects.* In outbreaks of some magnitude it is often difficult to keep track of patients or suspects so that none with positive cultures are released from isolation. We have used a card system, in slightly modified form, such as is shown in illustrations 2 and 3. The card is red in color, 6 x 5 inches in size (i. e. the size of two 3 x 5 index cards joined at their 5 inch sides), and perforated through the center for ease in separation. As soon as *any patient has a diarrheal stool or if a patient is admitted with diarrhea or a history of diarrhea,* the nurse immediately attaches the half card marked "Isolation D. P." to the chart which hangs on the bed in clear view. "D. P." refers to "dysentery precautions," the latter terminology being avoided for purely psychological reasons. The back part of this card marked "Instructions to Nurse" clearly indicates that she is to: (1) Isolate the patient. (2) Notify the epidemiologist at once by detaching the other half of the card. (3) Send three fecal specimens to the laboratory on successive days. (4) Release patient from isolation only upon receipt of a signed certificate of release.

Upon receiving his half of the card the epidemiologist visits the patient as soon as possible and then forwards his card to the laboratory. The bacteriologist thereby is notified that he is to receive three fecal cultures, which if they are negative, are so entered on the card. It is then returned to the epidemiologist who, after examination of the patient, signs the "certificate of release." It will be noted that one-half of the double card marked "Isolation D. P." on the front and "Instructions to Nurse" on the back remains at the bedside. The other half marked "Fecal Cultures" on the front and "Certificate of Release" on the back, goes to the epidemiologist who, in having the bacteriologist enter reports of the negative cultures before returning it to him, has an accurate and unmistakable record before signing the release. This method is so simple that it is practically foolproof. Often a keen intern will delight in making an early diagnosis and attach the card himself. If the diarrhea is found to be due to some cause other than dysentery, no harm is done.

(d) *The use of prophylactic dysentery vaccine and serum from recovered cases.* We wish to stress the protective value of dysentery vaccine and serum from recovered cases. While our work in this field is still in its early stages we feel that it is of definite value in terminating outbreaks. The vaccine is made up of polyvalent strains, preferably those isolated from patients involved in the outbreak, is of high antigenic-titer and relatively non-toxic. A fair degree of immunity can be attained in two weeks or less. This procedure is active immunization. Passive immunization is obtained by the use of serum administered subcutaneously, preferably from recovered adult patients. Whole blood can be used intravenously,

Fecal Cultures

This is to certify that the fecal cultures in the case of are:

	Date	Report
1.		
2.		
3.		

(Bacteriologist will kindly return this card to Dr. Smith as soon as three negative cultures on successive days have been obtained.)

Signed:.....

Bacteriologist.

ISOLATION

D. P.

Illustration 2.

but this requires preliminary tests for compatibility. All blood donors should be subjected to the Wassermann and Kahn tests. In outbreaks it is generally quite easy to get volunteer donors. The sterile serum may be separated and kept in ice-box storage until used.

All patients with acute bacillary dysentery should receive prophylactic immunization against the chronic form as soon as the acute symptoms have subsided. This occurs usually by the end of the third week. Chronic ulcerative colitis or chronic distal ileitis are far more serious than the average acute dysentery and the medico-legal aspects have a corresponding significance. The D-C vaccine used for this purpose has been described elsewhere. [10, 21]

Role of the Nurse

Nurses on the obstetrical and pediatrics services were found to harbor the dysentery organisms in several outbreaks recently studied. It must be remembered that the specific germ comes from the intestinal tract of the person who has or has had the disease to the mouth of another who contracts dysentery. Babies are peculiarly susceptible to this disease since they apparently receive little or no immunity to it from the mother, even after breast feeding.[19] Direct contact infection is therefore common and specific instructions must be issued to each nurse. These are indicated in illustration 2, which are mimeographed instruction sheets entitled "Dysentery Precautions. Notice to Nursing Staff." Verbal instructions are useless since changes in personnel occur frequently.

For similar reasons it was found necessary to issue a notice entitled "Notice to Nursing and Lay Staff" indicating that there would be no loss of pay entailed by absence from duty due to dysentery. Instances of nurses, assistants and kitchen help with diarrhea remaining on duty were encountered repeatedly. Confidential inquiry revealed that the fear of loss of pay was the sole motive in not reporting sick, particularly in the cases of those afflicted with mild, though none the less communicative, types of dysentery. The notices referred to above are given to each

The Bronx Hospital

Instructions to Nurse

At the **FIRST SIGN** of a diarrheal stool from **ANY PATIENT,** isolate patient immediately and notify Dr. Felsen by attached card.

The Bronx Hospital

Notification of Diarrhea Case

This Card to Be Sent to Laboratory

Dr. Felsen:

Ward

Patient..... Room.....
has been isolated because of diarrhea and will not be released until we are notified. 3 stool specimens on successive days are being sent to laboratory for culture.

Date Isolated..... Signed:.....

Illustration 3a.

Release From Isolation

This card must be signed by Dr. Felsen
The patient named on reverse side of this card may now be released from isolation.

Date..... Signed.....

To be filled in by bacteriologist: 3 fecal cultures of patient named on this card were negative for B. dysenteriae on .....,

....., ..., Signed.

THE BRONX HOSPITAL

Diarrhea Precautions

Illustration 3b.

nurse already on duty as well as those newly engaged. The same procedure is followed with lay employees. In actual practice the chief danger of transmitting infection lies in those persons handling children and in the kitchen employees who handle the food and eating utensils.

Role of the Laboratory

We have made it a practice of carrying out routine monthly surveys of all kitchen employees as well as professional and lay help on the obstetrical and pediatrics services. Lists of the personnel are furnished by the administrative office and checked against the fecal specimens sent to the laboratory for culture. The purpose of this procedure is to *prevent an outbreak of dysentery* by picking up symptomless cases *before* an outbreak occurs. This has been eminently successful, we believe, for there has been no outbreak at the Bronx Hospital since 1933, although sporadic cases have been steadily admitted up to the present. The bacteriological examinations can be handled quite simply because specimens showing no colorless colonies on an Endo plate require no further study. Since hospital outbreaks usually arise from a newly admitted case of dysentery or as a result of intramural contact infection, detailed engineering surveys of cross connections, back siphonage, etc. are generally unnecessary.

Role of the Administrative Department

The superintendent of a hospital is placed in a position where he must weigh the price of undesired publicity attendant upon a dysentery outbreak, with a possible mortality of three per cent, and certain medico-legal implications against the additional costs of isolation, monthly surveys and special help. Once the superintendent has passed through such a crisis, when perhaps the very existence of his hospital has been threatened, his choice is immediate and unconditional. Periodic monthly surveys and prompt action along lines suggested in this paper during outbreaks is the cheapest procedure in the end. Economy of money and time and the avoidance of undesirable notoriety, while desirable in themselves, are of secondary importance when compared with our ultimate goal—the saving of human lives. Aside from the immediate mortality of acute dysentery we are now learning of the chronic forms of the disease (10.7 per cent by the end of one year in the follow-up studies of the Jersey City epidemic).[10, 11, 14, 15, 17, 21, 22] Those of us who are acquainted with the serious and intractable nature of these chronic infections (chronic ulcerative colitis, chronic distal or regional ileitis) know that the ideal therapy is *the prevention of bacillary dysentery.* Since the disease is entirely preventable our course is clear. By preventing bacillary dysentery we avoid the acute phase with its incident mortality as well as the chronic

Dysentery Precautions
Notice to Nursing Staff

Immediately upon detecting loose bowel movements isolate patient and notify Dr. John Smith. Use individual eating and cleansing utensils and individual bed pan. Sterilize eating utensils and bed pan after using. For cleaning bed use plenty of soap and hot water. For mattress use whisk broom-formalin sprinkling and air in sunshine. Keep basin with 5% lysol at each bedside and soak hands for three minutes before going to next patient. Individual gowns are to be used for handling sporadic cases.

Illustration 4.

Notice to Nursing and Lay Staff

All nurses and lay employees who have loose bowel movements are to report to Dr. John Smith at once and to stay off duty until released by the physician named. There will be no loss of position or pay.

Illustration 5.

form which is most insidious in onset, very resistent to therapy and only too frequently leads to chronic invalidism or death. The dysentery germ is no respector of money or person. On the contrary, a director's child is more apt to get the disease than the street ragamuffin who may have had the disease and is relatively immune. The personal nature of this problem, if brought home in its proper light, will generally elicit the full support of those who handle the purse strings. The saving of one baby's life is worth the cost of a decade of preventive therapy as outlined.

Bibliography

1. Wilks, S. and Moxon, W.: Lectures on Pathological Anatomy, 2nd Edit., 408, 1875
2. White, W. H.: Guy's Hospital Reports, 45: 131, 1888
3. Vedder and Duval: Jour. Exp. Med. 6: 181, 1902
4. Eyre, J. W. H.: Brit. Med. Jour., 1: 1002, 1904
   For the recent developments in the field of bacillary dysentery and supplementary bibliography the reader is referred to:
5. Felsen, J. and Osofsky, A. G.: Sonne (Duval) Dysentery, J. A. M. A. 103: 966, 1934
6. Felsen, J., Rundlett, E. V., Sullivan, J. and Gorenberg, H.: Atypical Flexner Dysentery. A Preliminary Report of the Jersey City Epidemic, J. A. M. A. 103: 1055, 1934
7. Lynch, J. M. and Felsen, J.: Nonspecific Ulcerative Colitis, Arch. Int. Med., 35: 433, 1925
8. Felsen, J. and Osofsky, A. G.: Control Agglutination Studies against B. Dysenteriae on the Serums of 300 individuals in the New York City Area, Am. J. Pub. Health, 25: 1027 (Sept.) 1935
9. Felsen, J.: Clinical Notes Concerning Distal Ileitis as a Manifestation of Bacillary Dysentery, Am. J. Dig. Dis. and Nut. 1: 782, 1935
10. Idem: Nonspecific Ulcerative Colitis, Terminal (Distal) Ileitis and Bacillary Dysentery, N. Y. State J. Med. 35: (June 1) 1935
11. Felsen, J. and Gorenberg, H.: Chronic Dysentery, Distal Ileitis and Ulcerative Colitis. A Follow-up of the Jersey City Epidemic of Bacillary Dysentery, Am. J. Med. Sc. 192: 553 (Oct.) 1936
12. Felsen, J.: Appendicular Form of Bacillary Dysentery (with notes on mesenteric adenitis and inflammation of the distal portion of the ileum), Am. J. Dis. Child. 50: 661 (Sept.) 1935
13. Idem: Bacillary Dysentery. Acute Fulminating Type with Marked Toxic Neutropenia, N. Y. State J. Med. 35: (Oct. 15) 1935
14. Idem: New Clinical Concepts of Bacillary Dysentery, Distal Ileitis, Chronic Ulcerative Colitis and Non-specific Granuloma. Their Common Pathogenesis, Am. J. Digest. Dis. and Nut. April 1936
15. Idem: Acute and Chronic Bacillary Dysentery, Am. J. Path. 12: 395 (May) 1936
16. Idem: Cases of Intestinal Ulceration with a Special Reference to Amoebic Dysentery, Am. J. Dig. Dis. and Nut., 1: 297, 1934
17. Idem: New Clinical Concepts of Bacillary Dysentery, Trans. Amer. Proct. Soc., 1935
18. Idem: Bacillary Dysentery. Preventive Medicine, N. Y. Acad. Med., 6: (May) 1936
19. Idem: The Susceptibility of the Newborn to Acute Bacillary Dysentery. With Serological Data on the Placental Transmission of Antibodies to B. Dysenteriae, Am. J. Dis. Child. (in press)
20. Idem: The Pneumonic Type of Bacillary Dysentery, N. Y. State J. Med. 37: (Feb. 1) 1937
21. Idem: The Relationship of Bacillary Dysentery to Distal Ileitis, Chronic Ulcerative Colitis and Non-specific Granuloma, Ann. Int. Med. 5 (Nov.) 1936
22. Idem: Intestinal Polyposis, Adenomatosis Coli and Polyposis Cystica Intestini, Am. J. Dig. Dis. and Nut., 3: 8, 589

SUBSCRIPTIONS TO *HOSPITALS*

The annual subscription price to *HOSPITALS* is $2.00, and is included in the payment of annual dues for each institutional and personal member of the Association. Members may order additional subscriptions at the rate of $2.00 a year.

The subscription price of *HOSPITALS* to those who are not members of the Association is $3.00 a year.

Single copies may be secured for 30 cents a copy.

Provision for Care and Training of Feebleminded in Massachusetts

C. STANLEY RAYMOND, M.D., Superintendent
Wrentham State School, Wrentham, Massachusetts

THERE has always been a great variation in the intellectual capacity of individuals in any recorded age of civilization. A few outstanding leaders appear in each generation followed by a larger number of superior people, in advance of the great mass of the intellectually average. Below these are the dull, the borderline defectives, and the feebleminded. The population of any city or town in the world could be divided from the standpoint of intellectual capacity into the above groups. The term *feebleminded* is used in Great Britain to denote the high-grade mental defective above the imbecile level, but in this country the term has a broader use and includes the idiots, imbeciles and so-called *morons* of all grades.

Civilization was slow in providing training and protection for the feebleminded. Provision was made for the blind and deaf long before the first recorded attempts were made early in the nineteenth century to educate children who showed marked mental retardation.

First Attempts Toward Training Feebleminded

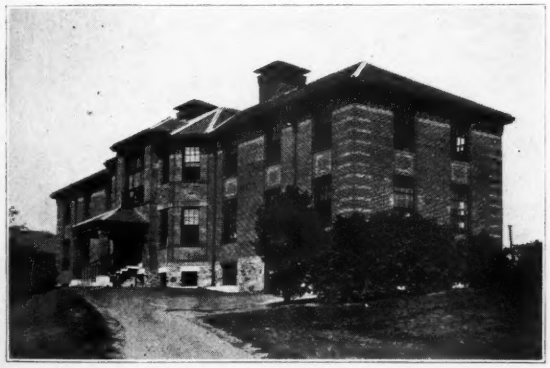
These first attempts were made by a group of French physicians beginning with Itard, Physician-in-Chief at the National Institute for Deaf and Dumb at Paris, who made an attempt to educate an idiot boy found running wild in a forest. He spent five years in trying to teach this boy, without success. A few years later Dr. Ferret, physician at the Bicêtre, in Paris, tried to teach a few of the somewhat brighter defectives confined to this hospital to read and write, and to train them in habits of cleanliness and order. In

Airplane View of Part of Wrentham State School

1831 Dr. Fabret attempted similar work at Salpétrière, and two years later Dr. Voisin opened a private school for idiots in Paris. None of these attempts were successful enough to warrant their continuance.

In 1837 Dr. Edward Séguin, a pupil of Itard and Esquirol, began private instruction of idiots at his own expense. The methods which he established for training the special senses of sight, hearing, touch, taste, and smell, along with certain simple directed physical exercises, became so successful that in 1844 the Academy of Sciences in Paris highly commended his work and agreed that his methods were the best that had been evolved up to that time.

Dr. Séguin continued his private school in Paris until the revolution of 1848. He then came to America, where he assisted in establishing schools for defectives in various states. His sense training methods have been elaborated by the late Dr.



Boys' Dormitory of the Walter E. Fernald State School

Walter E. Fernald and others, but his principles of training low-grade defectives are still in use.

The first institution in America for the care and training of the feebleminded was started in South Boston in 1848 in conjunction with a school for the blind. It was financed by private funds under the direction of a corporation, and received gradually increasing grants from state funds. Dr. Samuel Gridley Howe, famous as an educator of the blind, was the first superintendent.

The Development of Training

New York, Pennsylvania, and Ohio developed institutions soon after Massachusetts. During the next forty years, fourteen other states made some institutional provision, so that in 1892 there were nineteen public institutions in America caring for a total population of 6,000 mentally defective individuals in seventeen states. Public interest was aroused during this period by the pioneer work

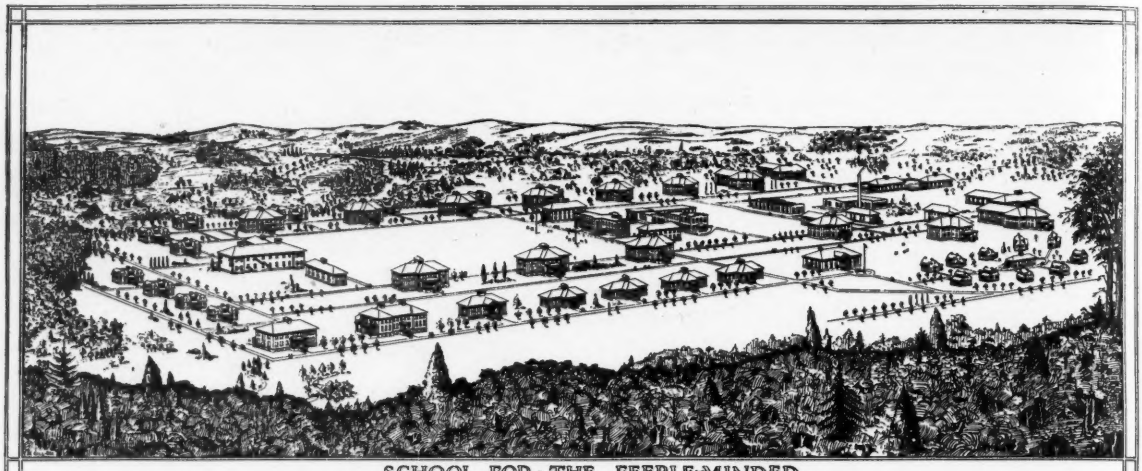
Standard Type Dormitory

of Doctors Howe, Wilbur, Kerlin, Rogers, and Fernald.

In 1904 there were twenty-five institutions in twenty states. Twenty years later there were fifty-one institutions in forty-three states, caring for a total population of 39,655. In a survey made five years ago there were eighty-three institutions for the mentally defective in forty-three states and one in the District of Columbia, with a total population of about 43,000. Five states have no institutional provision.

The demand for the admission of feebleminded children overtaxed the small institution in South Boston so that in 1887 a new institution to house 250 patients was constructed by the state at Waverly, and the patients from South Boston were transferred to become the nucleus of the new institution. It was thought at the time that this institution would be large enough to take care of all the feebleminded needing such care that Massachusetts would have for many years. The late Dr. Walter E. Fernald went there as the first superintendent, and during his thirty-seven years in that capacity he established standards of care, training and construction which have been copied in many other states and in many other countries. It was only a short time before demands for admission overtaxed the facilities of

Farm Dormitories



SCHOOL FOR THE FEEBLE-MINDED

the one large building, and in the process of enlargement Dr. Fernald built separate cottages for the different sexes, ages, and intellectual classifications.

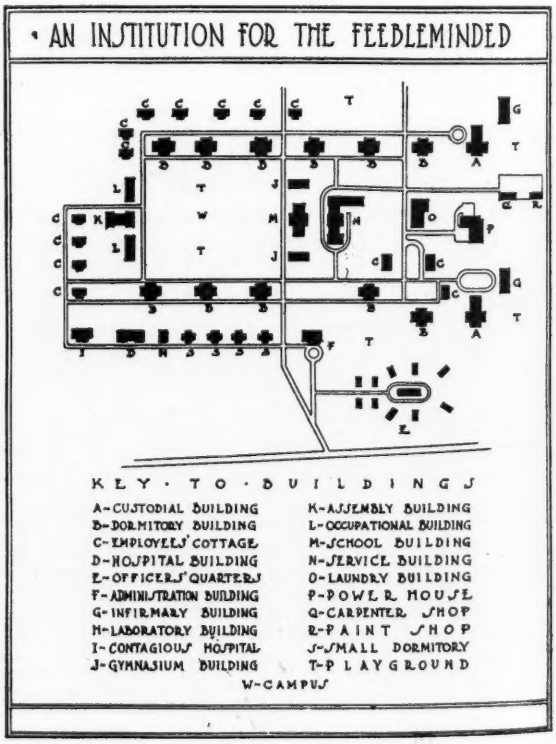
Training of Improvable Children

Entirely different resources and equipment were found to be needed for the high-grade active, improvable children than would be suitable for the low-grade and more helpless ones. Ample space was allowed around each cottage for separate playgrounds with equipment suitable for the ages and types residing in each cottage.

Most of the new institutions which have been built throughout the country since that time have been of the cottage system with ample acreage for farming, developmental projects, and separate playgrounds. The census of 1890 recorded a total of 95,571 feebleminded persons in the United States. At that time the higher grades of mental defectives were not usually recognized as such; school clinics had not been established and there were no facilities for making an accurate estimate of the total number of mental defectives. Most of the younger ones were kept at home, and the older ones who became social problems were placed in jails, insane hospitals, and in almshouses. There are at least 90,000 feebleminded individuals in Massachusetts alone, and it is very conservative to estimate 3,000,000 feebleminded persons in the United States.

Up to twenty-five years ago it was thought that practically all the feebleminded came from poor stock, and that they were an idle, vicious, disorderly group with criminal tendencies who should be permanently removed from society. This pessimistic viewpoint which was formerly held was due in part to the publicity given to researches concerning well-known defective families such as the Jukes, the Nam family, Hillfolks, Kallikaks, Ishmaelites, etc. About all the information at that time was obtained from a study of institutional cases, and the hovel type of defective was very properly commanding a great deal of public attention.

At the peak of this period of pessimism the late Dr. Walter E. Fernald began to get glimmers of something less gloomy from the examination of well disposed mental defectives from good fami-



lies who were seen in the out-patient clinics at his institution, and from the possibilities of extramural supervision of paroled and discharged patients. He observed that large numbers of superior families with one defective child were being brought to him for diagnosis as time went on. He was also seeing many well disposed, mentally defective children who were living in good homes where their limitations were understood and where they were receiving excellent care. He also found that many boys and girls who had been given training in the institution for many years were doing surprisingly well when permitted to return home on a trial-visit basis.

Parole Law

A parole law was enacted in 1931 which allows the trustees of an institution for the feebleminded to permit any inmate of the school to leave the institution on parole for such length of time and under such conditions as they may determine, and may, from time to time, extend the period of such parole. No length of absence on parole from a state school for the feebleminded may be construed as a discharge therefrom. Several hundred are now on parole from the state schools of Massachusetts and many hundreds have been discharged after making a good adjustment.

Traveling Psychiatric School

The compulsory establishment of traveling psychiatric school clinics in 1919 added greatly to the information concerning the size of the problem. It increased previous estimates, and also demonstrated the fact that at least ninety per cent of the feebleminded in any state must be cared for in the community. The law requires that the "school committee of every town shall annually ascertain, under regulations prescribed by the Department of Mental Diseases, the number of children three years or more retarded in mental development in attendance upon its public schools, or of school age and resident therein. At the beginning of each school year, the committee of every town where there are ten or more such children shall establish special classes for their instruction according to their mental attainments, under regulations prescribed by the department of education. A child appearing to be mentally retarded in any less degree may, upon request of the superintendent of schools of the town where he attends school, be examined under such regulations as may be prescribed by the department of education and the department of mental diseases."

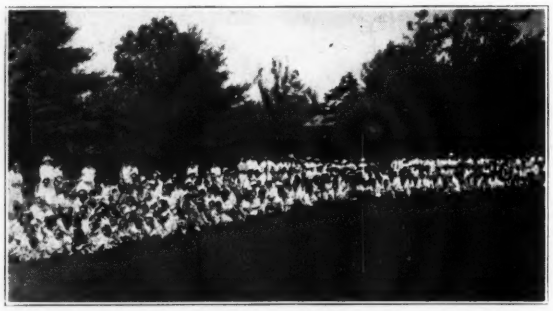
Up to date approximately 97,000 such examinations have been made. Traveling school clinics operate from fifteen institutions under the Department of Mental Diseases. A few special classes for retarded children were established long before this law was enacted; the first one in America being established in Providence, Rhode Island, in 1896, and the second one in Springfield, Massachusetts, in 1898. During the past sixteen years there has been a rapid increase in the number of such classes, and the Department of Education is now providing special training for over 10,000 backward children in 600

Kindergarten Class

special classes in the public school system. Complete studies of all retarded children in certain cities and towns show that from 1½ to 3 per cent of all children of school age are sufficiently retarded to need either the facilities of a special class or the protection and training available in an institution.

Heredity as a Causative Factor in Production of Mental Deficiencies

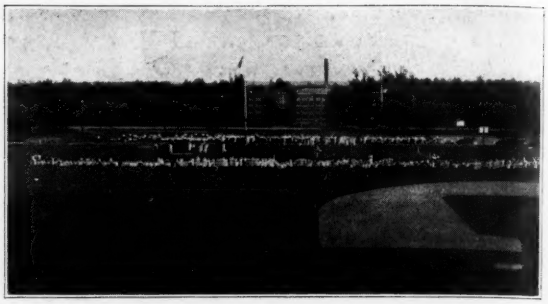
There is no doubt of the fact that heredity is the greatest single causative factor in the production of mental deficiency. Previous to the present century it was believed that ninety per cent of all feebleminded children were defective because of the poor germ plasm of the parents, but recent information concerning many other causative factors makes it necessary to lower this percentage materially. No class of society is exempt from this problem. Many mentally defective children are seen who come from intellec-



Section of a Group Assembled for an Out-of-Door Entertainment

tually superior families and whose mental defect can be directly traced to inflammatory brain disease, to injuries of the head before, during or after birth, to convulsions incident to whooping-cough or some other childhood disease, or to an endocrine imbalance. About six per cent of all institutional mental defectives show blood or spinal fluid findings of congenital syphilis, and it is the belief of many who are dealing with this problem that syphilis is a bigger factor than can be demonstrated by any known test.

Massachusetts has three state schools for the feebleminded, with a total population of slightly over 5,000, which is only a little more than five per cent of the known feebleminded in this state. The first one already mentioned has been named after its builder and is known as the Walter E. Fernald State School. The second one, the Wrentham State School, was opened in 1910, and the third, the Belchertown State School, in 1917.



Part of Athletic Field with Schoolhouse in the Distance

Each school has a long waiting list and a fourth institution is urgently needed. These schools comprise three of the sixteen institution units under the direction of the Department of Mental Diseases. A commissioner heads this department and most of the business and statistical work is done through the central office, although each institution operates largely as a separate unit under the control of a superintendent and a board of trustees.

How Feebleminded Individuals Are Registered and Admitted

When any feebleminded individual is identified either in the public school clinics or the outpatient clinics of the institutions, that individual is registered with the Division of Feebleminded in the Department of Mental Diseases. All applications for admission to the institutions are recorded in the central department and information concerning all admitted patients is sent to that department for statistical study. No child is recommended for admission to a state institution merely because of mental deficiency. Many of these children come from excellent homes where they are given adequate care and supervision, and if their community provides special class facilities there is no need of considering admission to a state institution. Those who do come to the three state schools have some moral, physical,

Wrentham State School Band Leading a Parade of Children

Nursery for Young and Improvable Defectives

economic, or family problem in addition to their mental deficiency, which makes it urgent to remove them from the community.

As soon as a child is admitted, all of the available yardsticks are applied, such as physical examination, psychological, school, and performance tests. A program is then arranged for each child on the basis of past accomplishments and expected development. For example, if a boy fourteen years old with a mental age of eight years is able to do some high second grade work with credits in low third grade work, he is placed in a school class one-half of each day that provides suitable stimulation and yet gives him a chance to achieve some success each day. The other half day is spent in training along such industrial lines as experience has shown are within his intellectual range and physical development.

Scholastic work even among the very high-grade defectives seldom gets beyond the fifth grade, and although all children should have an opportunity to take as much school work as possible, their eventual success will depend upon their skill along industrial lines. We have come to know by experience what occupations are possible at various mental age levels, so that much waste of time and material is avoided by not attempting to teach a six-year mind to do work requiring intelligence on the level of nine or ten years. For instance, a big boy with a mental age of seven years may learn to do simple carpenter work and painting, but it would be a waste of material and time to have him attempt to do any carpentry with expensive material or to do interior decorating, requiring a higher mental level. Also, a girl with a mental age of seven years may learn to crochet and knit along with other simple handwork, but it would be disastrous for her to operate a power sewing-machine or to attempt any elaborate pattern of embroidery or other fancy work.

If a child of the high-grade moron type remains in the institution for eight or ten years he is carried along in school as far as he is able to progress, or until he is sixteen or seventeen years old. Then the entire time is spent in training along many lines of industrial activity. No mentally defective person ever becomes an expert in carpentry, painting, animal husbandry, or other pursuits, but he may become so proficient along many lines that he proves to be useful to his employer and succeeds in holding jobs because of his eagerness and willingness to do any type of work required of him.

Social Training of the Feebleminded

In addition to the scholastic and industrial training, much time is spent on social training, as social failure in the community is frequently the principal reason for a child's entrance to an institution. Much attention is given to cleanliness of both clothing and body, good table manners, politeness, and orderliness at entertainments, dances, house parties, etc. A great variety of recreation is furnished. Competitive sports have proved of great value in teaching the pupils to give and take without malice. Many children who come to the state institutions with a community record of bad behavior frequently make a very rapid adjustment when placed under the supervision of persons who understand their limita-

View of Institution Laundry

tions and who provide opportunities for work and recreation suitable for their mental level.

The expectancy of life in the feebleminded is lower than it is in those with average intelligence. It is, of course, much lower in the idiot class than in other degrees of feeblemindedness. Noisy, untidy, destructive idiots should be placed in an institution as soon as possible, because they often come from families in which the other children are normal, and the idiot child receives much more than its share of the mother's care and attention. Although the death rate of the institutions is thereby increased, it is our opinion that the home should be relieved of such a child as soon as possible.

Many institutions throughout the country do not admit children under the age of six years, but a hospital department for mentally deficient babies of the idiot class provides a much needed and much appreciated community service. Most children of the imbecile type are unable to profit by any scholastic work in the public school system, and in most instances they should receive institutional care. Occasionally such a child may be properly kept at home, particularly if the parents live in a sparsely settled section where urban dangers and temptations do not complicate the problem.

Moron Problem in the Community and in the Institution

The moron presents the most serious problem both in the community and in the institution. This group is often not recognized until they have failed to make progress after spending a few years in school, and is often not admitted to the institution until anti-social behavior has become a habit. A certain proportion of the latter group improves sufficiently after years of training so that they become eligible for parole either in their own homes or in wage homes.

The various pathological types such as the microcephalic, hydrocephalic, Monogoloid, cretin, and spastic paralytic usually require institutional care, although many do remain at home, as they are not public school problems and simply require care, protection and habit training.

A great majority of all patients admitted to institutions for the feebleminded have to remain throughout their lifetime. The question is often asked as to why such elaborate efforts are made to provide training for a group, most of whom will never become self-supporting. It is our belief that the training of mental defectives has a threefold purpose:

1. To give every child an opportunity to develop to the limit of his capacity.

2. To take advantage of the fact that a trained defective is easier to live with and less expensive to care for than one who is untrained.

3. To prepare a considerable number of high-grade defectives to return to the community as industrious, wage-earning, well-disposed members of society after years of training.

The state school at Wrentham has recently established a department for research into the causes and methods of prevention of mental deficiency, and an entire building is set aside for this purpose. The equipment is being assembled and the personnel is already engaged, so that within the next few months pathological, bio-chemical, and other scientific investigation will be undertaken.

What a State Program Should Include

Any state program for the care of mental defectives should include:

1. Early identification
2. Central registration of all known feebleminded
3. Educational facilities both in the public school system and in the institutions
4. Protection, particularly during the formative years.
5. Segregation for those who are incapable of living at home
6. Supervision of the ninety per cent or more who are in the community as well as supervision of those paroled from state institutions
7. Research into the causes of mental deficiency and methods of prevention

Contagious Hospital

The above items were stressed for many years by the late Dr. Walter E. Fernald and the late Dr. George L. Wallace and others, and have not been improved upon since their time.

Although the state of Massachusetts is probably doing fully as much as any state for its mental defectives, it is providing for not more than half of those who need either special class or institutional care. Every mentally defective child has a right to the pursuit of happiness and the opportunity to develop to the limit of his capacity. The Massachusetts program aims for that end.

Dr. Washburn Retires as Commissioner

Dr. Frederic A. Washburn, Commissioner of Institutions of Boston, having completed the job of reorganization in the Institutions Department and at the Long Island Hospital, as requested to do, tendered his resignation effective February 1, 1937. He was succeeded by Dr. John W. Lane.

At the request of the Board of Trustees of the Cambridge Hospital, Cambridge, Massachusetts, Dr. Washburn has accepted the superintendency of that institution to succeed Josephine E. Thurlow, who was appointed chairman of the Board of Trustees of the Boston State Hospital by Governor Hurley.

Doctor Washburn's Letter of Resignation

190 Bay State Road, Boston,
January 15, 1937.

Dear Mr. Mayor,—I hereby present to you my resignation of the office of Commissioner of Institutions, City of Boston. If it is agreeable to you I should be glad to have the resignation take effect February 1, 1937.

I have already given you my reasons verbally for this action on my part.

May I express to you my appreciation of your constant support. I value your friendship highly and I have had a "bully" good time.

Yours sincerely,
Frederic A. Washburn, M.D.

Mayor's Reply to Doctor Washburn

Dr. Frederic A. Washburn,
190 Bay State Road,
Boston, Mass.

Dear Dr. Washburn,—It is with extreme reluctance that I accept your resignation, to become effective at the close of business on January 31, 1937. But knowing your wish to be relieved of the heavy burdens which you have carried since you have been at the head of the Institutions Department, and keenly realizing that you have thoroughly performed the job that I asked you to do, namely, to reorganize the Institutions Department, and particularly, the Long Island Hospital division of it, I accept your resignation.

In doing so I want you to know that the very thorough and admirable work that you have done is realized by me and every citizen of Boston who has come in contact even in the remotest way with the Institutions Department. The department itself, under your control, has attained a degree of efficiency never before known in the City of Boston, each division is working in harmony with every other division and the reforms instituted at Long Island have been excellent in every way. A spirit of harmony and contentment pervades the whole Island not only among patients and inmates but also among the employees and the result of your patient labors are clearly evident on every hand.

As Mayor of the City of Boston I thank you for your loyal and efficient service and assure you that it is appreciated not only by me but by all the citizens of Boston whom I have the honor to represent.

Yours truly,
Frederick W. Mansfield, Mayor.

Financial Importance of General Hospital Psychiatry to Hospital Administrator

EDWARD G. BILLINGS, M.D., Director, Psychiatric Liaison Dept.*; Assistant Professor of Psychiatry
WILLIAM S. McNARY, Business Manager
MAURICE H. REES, Ph.D., M.D., Dean and Superintendent

University of Colorado School of Medicine and Hospitals, Denver

THE HIGH INCIDENCE of psychiatric problems in the private and general hospital patient populations has long been recognized by the clinical and administrative staffs of medical institutions. With "Psychobiology" or the "physiology of the total person" (A. Meyer) rapidly becoming a requisite basic course in all medical school curricula, and with the diagnostic and therapeutic methods in psychiatry becoming practicable during recent years on the behalf of the patient in any hospital, an increased need for the development of psychiatry in the general hospital is becoming more apparent.

In previous communications, one of the authors (E. G. B.) formulated the plan of organization and development of the Department of Liaison Psychiatry *in*[1] and attempted to point out the psychiatric needs *of* the Colorado General Hospital.[2] These papers dealt particularly with the clinical, didactic, and research values of such an expansion of general hospital medicine and surgery. In one of the papers[2] the maintenance cost of such a department to the school and hospital was elucidated. However, to the administrator considering such a development in his institution, another question arises, viz: *What does the consideration of patients from the psychiatric aspect mean in terms of decreasing hospital days and therefore in saving dollars and cents?*

Decreasing the Hospital Stay

The purpose of this article is to present certain statistics from the University of Colorado School of Medicine and Hospitals which, in our instance and circumstance at least, seem to indicate that the functioning of the Psychiatric Liaison Department (organized September, 1934) has decreased the hospital stay of psychiatric patients on the wards of the Colorado General Hospital and saved the institution money. This will be presented by showing briefly:

(a) The average period of hospitalization (i. e. *stay*) and net cost per "day" and "stay" statistics for all patients on all services in the general hospital during the years 1934-1935 and 1935-1936 and their relationship to those over a period of 9 years, 5 months;

(b) Corollary statistics for all patients seen by the psychiatrist in the general hospital during the years 1934-1935 and 1935-1936;

(c) Statistics of expectancy that at this writing seem to indicate that the present investment in establishing and maintaining the department ultimately will pay dividends in the form of saving on patient cost, certainly sufficient to defray a major portion of the yearly cost of a complete, full-time organization of liaison psychiatry.

The Colorado General Hospital is an institution maintained by the State of Colorado in connection with its medical school. It is fully accredited by the American College of Surgeons, by the American Hospital Association and by the American Medical Association. It is fully and completely physically equipped, maintains a resident staff of two full-time residents and twelve rotating interns, accommodates 126 adult patients, 32 children and 20 infants. Since the institution is state maintained and a teaching hospital having a long waiting list, its beds are practically always filled to capacity. The admissions during 1934-35 totalled 3,563 and 3,471 in 1935-36.

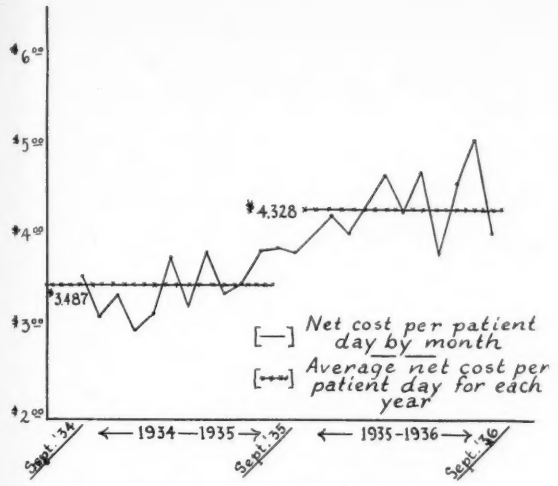
Average Period of Hospitalization and Net Cost Per Day

The statistics to follow are based on accurately kept figures as compiled by the accounting office‡ and the record room‡ of the University Medical School and Hospital, all under the personal supervision of two of the authors (M. H. R. and W. S. M.). The cost per day of hospitalization per

*The Psychiatric Liaison Department, financed by the Rockefeller Foundation, is a division of the Department of Psychiatry of The University of Colorado School of Medicine.

[1]Billings, E. G.: Teaching Psychiatry in the Medical School General Hospital, J. A. M. A., 107: 635-639 (Aug. 29, 1936).

[2]Billings, E. G.: The General Hospital; its Psychiatric Needs and the Opportunities it offers for Psychiatric Teaching, (To be published soon in the Amer. Jr. Med. Sciences).



Net Cost per Patient Day on the Wards of The Colorado General Hospital Sept. 1, 1934 to Sept. 1, 1936

Fig. 1

patient is the net cost which is computed in a way that is comparable to that used by most contemporary and similar institutions.

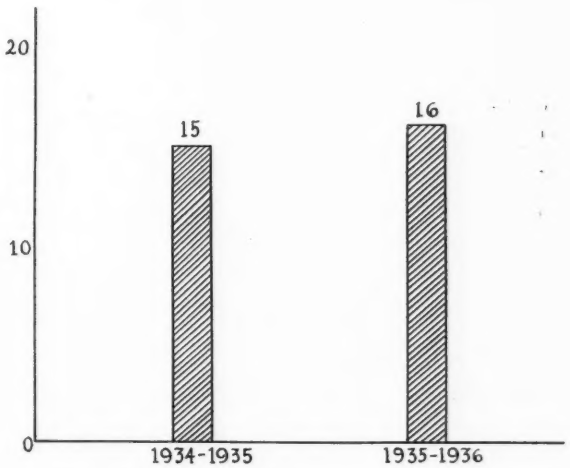
In this report, data concerning two categories of patients are compared. One includes all the patients on all services of the Colorado General Hospital and the other embraces those patients referred from the various wards of the hospital to the Psychiatric Liaison Department for examination and treatment. The cost per day for the psychiatric case is therefore the same as that noted for "all patients on all services" during a given period of time.

In Figure 1 are graphically depicted the monthly averages of the net daily cost of hospitalization per patient in the Colorado General Hospital from September 1, to September 1, during each of the two consecutive years of 1934-1935 and 1935-1936. These figures are based on the net cost of caring for *all patients on all services of the hospital* (viz: medicine, surgery, gynecology, obstetrics, urology, neurology, orthopedics, dermatology, and syphilology, ophthalmology, oto-laryngology, pediatrics, and proctology). The daily net cost per patient per day for the year 1934-1935 was $3.487, and for the year 1935-1936 was $4.328. The increase in cost from the first to the second year was $0.841.

The average period of hospitalization per patient (based on all patients on all services) for the year 1934-1935 was 15 days and for the year 1935-1936 was 16 days (see Fig. 2).

To compute the average net cost per patient "stay" in hospital for each of the two years, the average number of days per patient "stay" was multiplied by the average net cost per day. These figures are graphically represented in Figure 3. It will be noted that the average net cost per patient "stay" during 1935-1936 was $16.943 more than in 1934-1935. This was due to the increase (average) of one day in the period of hospitalization and the above mentioned rise in per diem cost.

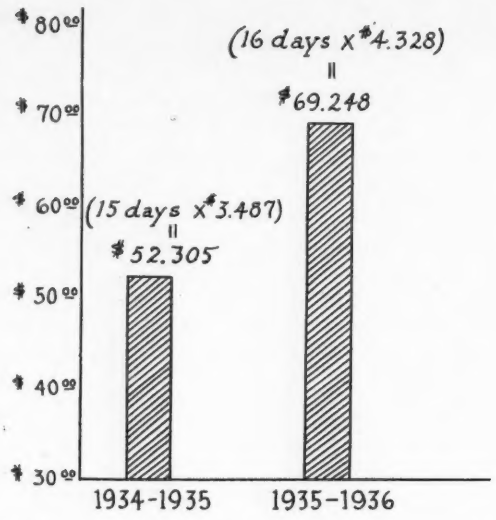
During the year 1934-1935, the first year of the Psychiatric Liaison development in the hospital, the average hospital "stay" required by the psychiatric case was 28.1 days. During the second year, 1935-1936, this figure was decreased to 22.9 days (Fig. 7). The result in dollars and cents was that in the second year, the average cost per *psychiatric* patient "stay" in the hospital rose only $1.127 (Fig. 4) as against the $16.943 increase for *all patients on all services* (Fig. 3). It is obvious from the graph in Figure 4 that during these two years the average cost of hospitalization (i. e., "stay") of the psychiatric patient in the General Hospital was greatly in excess of that for the average patient on all services. However, as will be shown later, this is actually not the case when statistics are based on less variable figures, at least on figures upon



Average number Hospital-Days per patient (all patients on all services) on the wards of The Colorado General Hospital during the 2 years 1934-35 and 1935-36

Fig. 2

[1]The authors wish to thank Esther Dimchevsky, Psychiatric Liaison Departmental social worker, G. Arnold Logan, accountant, Margaret Neale, record librarian, for assisting with the statistics, and Waneeta Stevic, artist, for making the graphs.



Average Net Cost per patient "stay" (all patients on all services) in The Colorado General Hospital during the 2 years 1934-'35 and 1935-'36. [Statistics based on average net cost per diem per respective year (Fig. 1) X average number hospital days per patient per respective year].

Fig. 3

which predictions for the future can be substantially placed.

Financial Value of a Psychiatric Service in the General Hospital

In order to make any substantial predictions concerning the financial value of a psychiatric service in the general hospital, the average cost per patient per diem and the average patient "stay" in hospital were computed over succeeding periods of time during which economic and financial factors varied considerably.

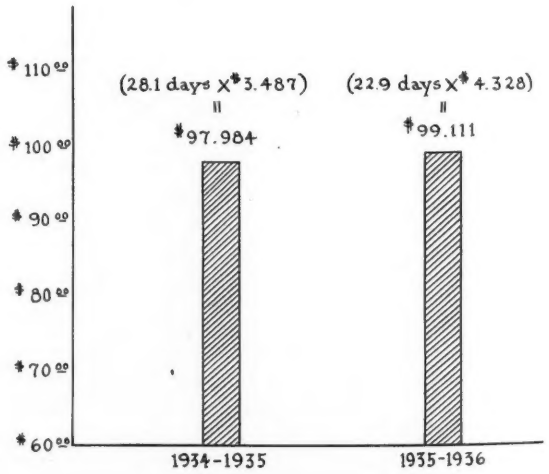
In Figure 5 are plotted the net costs per patient day (based on all patients on all services) of hospitalization per year for 9 years and 5 months, beginning in 1927. Financial and economic records of the Rocky Mountain region show that this span of time includes three periods, viz., the pre-depression period (1927-1931), the period of depression (1931-1935), and the post depression period of recovery (1935-1937). It is of note that the average net cost per diem, per patient, in these three periods has slightly decreased successively. However, from the general trend of the curve we would anticipate a rise in cost, but one not in excess of the figure during the pre-depression period. For the total of 9 years, 5 months, the average cost per diem, per patient, was $4.702.

The number of days constituting the average patient "stay" in hospital varied irregularly from 15 to 17 during this same period of time and was not apparently dependent on the financial and economic status of the State. The average hospital "stay" for this period of 9 years, 5 months, was 15.77 days.

Using these figures ($4.702 as the average cost per patient day in hospital and 15.77 days as the average period of hospitalization per patient —all patients on all services), the average total net cost for each patient's hospitalization over a period of 9 years and 5 months was $73.95. Since these figures are the averages taken during probably the most widely varied economic periods of modern medicine, we feel that it is possible to predict that fluctuations in the cost of daily hospitalization of a patient and the period of hospital stay will not vary greatly from these averages during the next ten years.

Therefore, with these data for comparison and deduction established and a premise made on which reasonably to base calculations for the future, the socio-economic-administrative side of the psychiatric patient found in the Colorado General Hospital, follows:

In Figure 7 are plotted the average number of days composing the hospital "stay" of the patients referred from the general hospital wards



Average Net Cost per Psychiatric Patient "stay" on the wards of The Colorado General Hospital during the 2 years 1934-'35 and 1935-'36

Fig. 4

to the Psychiatric Liaison Department for examination and treatment. In the year 1934-1935 this period equaled 28.1 days and in 1935-1936 averaged 22.9 days (a decrease of 5.2 days in 1 year). These figures, if translated into dollars and cents by multiplying them by $4.702, the long term average per diem cost per patient, show a striking decrease in cost per psychiatric patient "stay" from the year 1934-1935 to that of 1935-1936 (Fig. 6). In the first year of the Psychiatric Liaison Department's activities, the average net cost per patient "stay" in the hospital was $132.126. During the second year the figure dropped to $107.675, a decrease of $24.45 per patient in one year's time. As previously noted, the computed long term average net cost per patient "stay" (all patients on all services) in the hospital is $73.95. A further decrease of $33.725 (Fig. 6—Graph A) in net cost per psychiatric patient stay is therefore the economic goal to be striven for by the Department of Liaison Psychiatry cooperating with all other departments of the institution. We feel that on the basis of the progress made in one year and on the facts at hand (not incorporated in this paper) concerning 1936-1937 statistics, this can, within reasonable limits, be accomplished in a period of another two and one-half years.

Such a prediction we believe to be tenable if

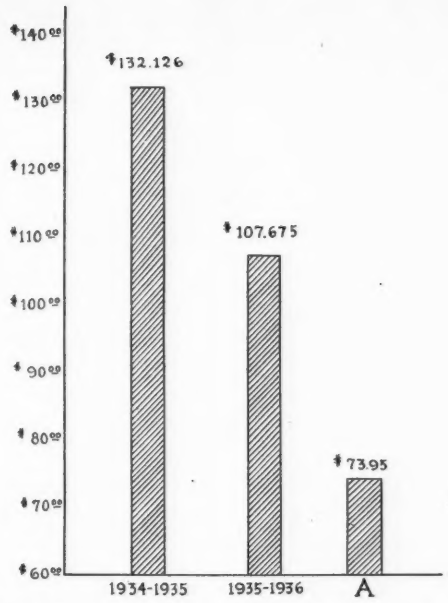
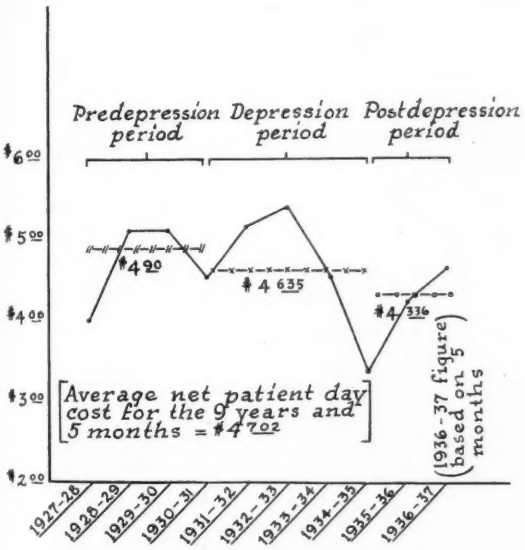


Chart showing net cost per psychiatric patient "stay" (based on $4.702 per day, the average net cost per day for 9 yrs.-5 mos.—See Fig 5.) during first two years of psychiatry in the Colorado General Hospital and showing a decrease of $24.45 in cost in 1 year.

Graph A, for comparison, shows the average net cost per average "stay" for all patients on all services which should be approximated as the intern and non-psychiatric staff understand and treat the patient as a whole.

Fig. 6



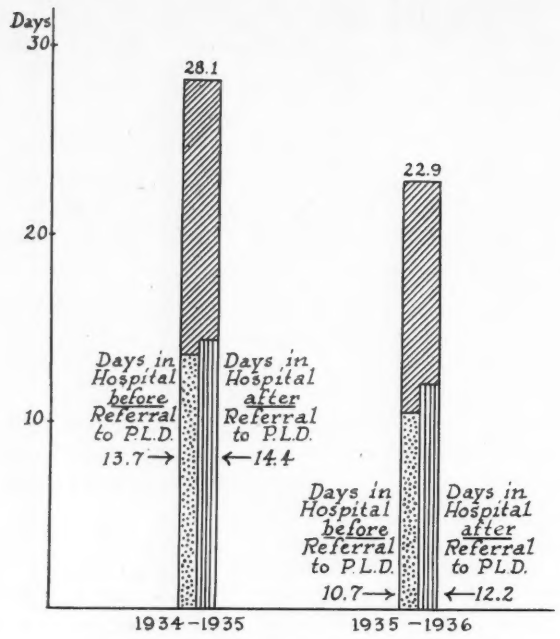
Net cost per patient-day (based on all patients on all services of The Colorado General Hospital) with average patient-day cost during the Pre-depression, Depression, Post-depression periods

Fig. 5

the average number of days per hospital "stay" and the average cost per day of patients remain more or less constant because of one very simple yet highly important fact, namely, the teaching of the medical student, the intern and the non-psychiatric staff physicians the basic principles of psychobiology and psychopathology as they occur in the everyday practice of medicine—long the goal of the Division of Psychiatric Education of the American Psychiatric Association.

Two Phases of Hospitalization for Psychiatric Patients

Referring again to Figure 7, it is of note that the hospital stay of psychiatric patients during each of the two years is composed of two phases of hospitalization, viz., the period that the patient is in hospital *before being referred* for psychiatric study and that *after referral*, during which examinations and treatment are concluded to the extent that the patient can be discharged. In 1934-1935, such a patient, on an average, was occupying a hospital bed for 13.7 days before being seen by the psychiatrist. In 1935-1936 this figure had dropped to 10.7 days, a decrease of 3 days ($14.10 per patient). Why did this occur? The answer is that in that period of time



Average Number Hospital-Days Per Psychiatric Patient on the Wards of The Colorado General Hospital during the 2 years 1934-'35 and 1935-'36

Fig. 7

the student and the resident staff had formed a better understanding of personality functioning and had learned that if the complete complaint of the patient and some of the facts of his personality development are obtained and corroborated by specifically outlined tests, a diagnostic formulation can be arrived at far more easily and accurately than by taking little of the facts as given by the patient and then relying on x-ray and test tubian tactics to "rule out" something or other. If the average intern can be taught (and he can be—he will have to be if he is to keep up with the advancement of medicine) to elicit the complete complaint of his patients and to understand those complaints in terms of psychobiology as well as physics, chemistry, anatomy, and physiology, the diagnostic period should decrease to an average total of not more than three days.

In this same chart (Fig. 7) the second phase (that of psychiatric examination and treatment) of the patient's stay decreased from 14.4 to 12.2 days in one year's time. This again was the result of the intelligent cooperation of the non-psychiatric staff of the hospital. This figure can hardly be expected to decrease for obvious reasons.

However, if the *diagnostic* or first phase of the patient's stay is decreased to a total of three days and the number of days required for the second phase remain at 12.2 days, then the average total "stay" in hospital of the psychiatric patient will fall well within the 15.77 days (for all patients on all services) and the total net cost per "stay" will have fallen to the basal net cost of $73.95 (Fig. 6—Graph A). From our calculations and the general way in which psychobiology and psychiatry are being accepted and utilized by the students and staffs of the University of Colorado Medical School and Hospitals, we feel reasonably sure that the accomplishment of the financial-psychiatric goal can be attained by 1939, the end of the first five years of liaison psychiatry in the general hospital.

Psychiatric Liaison Department Justifies Itself Financially

During *each* of the two years (1934-1935 and 1935-1936) the Psychiatric Liaison Department examined and treated on an average of 146 patients on the wards of the hospital. If, at the end of the first five years of the project, the average hospital stay for these patients is decreased from 28.1 days to 15.77, then, from 1939 on, each succeeding psychiatric patient's stay will have been lessened, on an average, by 12.33 days. If 146 patients per year continue to be psychiatric cases, then each year thereafter a total of 1,800 (12.33 days x 146 patients) hospital days will be saved per year. This figure, if rendered into financial facts by multiplying it by $4.702 (the average net cost per patient diem), reveals the startling fact that $8,464.446 would be saved in hospitalization per year.

The value of psychiatry as a part of all medicine, in the alleviation and amelioration of suffering, has long since been acknowledged. The financial side of psychiatry has been too often conspicuously absent from much of the medical and psychiatric writings of the day. For this reason this paper has been presented, as well as for the fact that it is felt that as soon as the monetary features of psychiatry can be generally understood as being as practical as some of the clinical aspects, then communities and hospitals will feel more free to avail themselves of facilities for the understanding and treatment of the "person as a whole."

The Smaller Neighbor

MARGARET E. KENNEDY, Superintendent
The Sanitarium of Paris, Paris, Texas

Men often build monuments that are more enduring than those made of marble or metal, are just as pleasing to our finer senses, and of far greater service to humanity.

For nearly a half century Dr. L. P. McCuistion has been the lovable and beloved family doctor to thousands of his people in North Texas and Oklahoma. His conception of a hospital is that it is more than an institution for the treatment and cure of the afflicted. He always thought of it as a home for the sick. And so twenty-five years ago he began to build his monument to his community. It is a thing of beauty, made to serve the patients who enter its portals and surround them with homelike things which will help in their restoration to health. Always a ranking surgeon in his state, he is a practical philanthropist and a creator of things cultural.—(Editor's Note.)

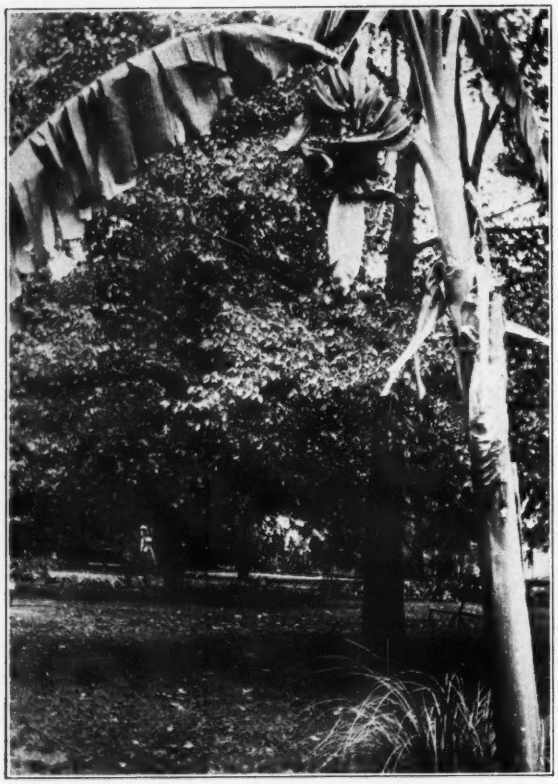
THE HISTORY of The Sanitarium of Paris, Paris, Texas, cannot be related fully without reference to the part played by its location, inception, organization, and equipment. Paris, "The North Star of Texas," is located sixteen miles from the Oklahoma border. Swept by a fire in 1916 it was rebuilt a beautiful modern city. Its hospital phase might be well described by an excerpt from Worley's Paris City Directory, 1936:

"The statement has frequently been made that Paris has more doctors per capita and fewer cases of sickness than any town its size in Texas, and this seemingly contradictory statement is accounted for by the fact that Paris has developed into a medical center. There are three first class hospitals in Paris. A survey of the records of these institutions show that patients come to Paris for medical treatment from Arkansas, Oklahoma, and from a radius of several hundred miles in Texas."

The Sanitarium of Paris, often referred to as "A dream come true," may be attributed to the vision, leadership, patience, and generosity of Dr. L. P. McCuistion.

Paris holds an enviable reputation for the unselfish spirit of its citizens in their efforts to promote the welfare and best interests of the community. The history of the building and growth of The Sanitarium of Paris is an example of active participation, responsibility for continuous work, and generosity of funds, counsel, and time to lay strong the foundation of this structure.

Main Building and Annex, The Sanitarium of Paris, Paris, Texas



Banana Trees Add to the Beauty of the Grounds

The focal point from which the Sanitarium evolved was the purchase of the John Martin home by Dr. L. P. McCuistion, on December 31, 1910. This typical southern mansion, built of brick-shaped blocks, hewn from stone, stood in the center of a beautifully wooded tract, occupying about a half of a city block, with approaches from three directions.

Next, in chronological order was the organization, on May 15, 1912, of a corporation which followed as a direct result of the meeting of several close friends who realized that the time had come to bring into closer relationship those who were striving for better and more complete services for the care of the sick in the Paris area.

Meanwhile, the John Martin property was taken over, remodeled, and furnished for the use of the nursing staff. The hospital was erected to the north, in front of the home, and connected to it by an arcade. This three-story, fire-proof building was constructed of concrete and brick, with an original capacity of 50 beds, and was so designed that additional wings could be provided for future extension. It was so situated that every patient's room overlooked a beautiful natural landscape.

Particular attention has been given to the beautification of the grounds, two divisions, Indiana Park and Kentucky Cozy Corner, have been developed. Pools, rose rests, arbor, benches, and concrete and stone picnic tables serve to provide a place for relaxation and recreation for families visiting patients.

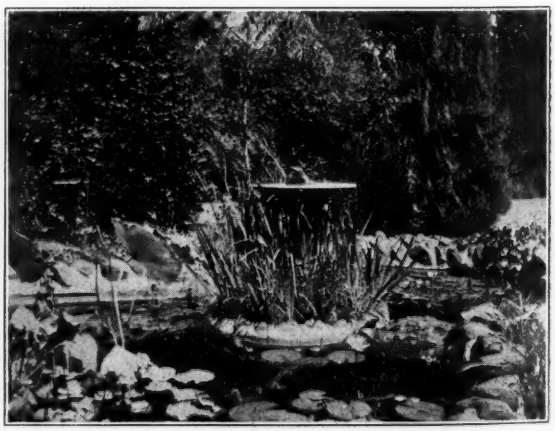
The hospital was opened for patients on Easter Sunday, April 12, 1914. "Since that good day, its doors have swung always inward to the slightest touch of suffering and distress."

The people of Paris who so gladly and freely gave of their money have never received a dividend on this investment, for it was understood and agreed in the beginning that the policy of the directors would be to convert all earnings into betterments, and thus necessitate no donations.

This policy has been followed consistently, with the result that the Sanitarium Farm was purchased in 1919; substantial additions were made to the Martin Home, and the Brooks Nurses Home was acquired in 1927 for the use of graduate and night nurses. The Annex, a three story building of the same type and structure as the original building, was completed in 1930. The capacity is now sixty-two beds and seven bassinets.

Looking to the future, plans are under way for the erection of The George Griffiths Memorial, a children's hospital of ten beds, on a site bequeathed to the Sanitarium by its good neighbor, Mrs. George Griffiths.

The Sanitarium of Paris is a general hospital, containing all the departments common to such hospitals. It is fully approved by the American College of Surgeons, and is a member of the American and the Texas State Hospital Associations. It has an x-ray department equipped for radiography, fluoroscopy, and therapy; a clinical and a pathological laboratory, surgery and urological equipment, and a separate maternity unit.



Fish Pool

The various departments are under the supervision of especially trained directors.

The staff of physicians numbers 12 members, 5 of whom have offices in the Sanitarium building. Four are members of the American College of Surgeons.

In addition, the Sanitarium has several departments which are not within the usual hospital classifications and which are here termed auxiliary departments. These include the farm, cannery, and library, although the library is now considered a major division of many hospitals.

Auxiliary Departments
The Farm

Among the merged departments of the complete organization, maintained for the hospital's existence, is the Sanitarium Farm. This thirty-acre tract of land is situated about a mile beyond the city limits and enjoys the usual city conveniences. It is operated, "not for profit," yet it does not entail a loss; but it does make it easy to enrich and give variety to the menus for the patients and hospital personnel.

From the administrative standpoint, all departments are necessary, but many would hesitate to venture into the practice of farming. Experience has proved, however, the value of the hospital farm management by its dividends of wholesome living for the well, and the restoration of patients to health.

By well organized hard work and by planning for future needs, the manager of the farm, with two regular helpers, during his tenure of sixteen years, has accomplished definite tangible things.

Lily Pond

Entrance to Indiana Park—a Division of the Grounds

His responsibilities include a truck farm, an orchard, berry patches, dairy, poultry keeping, and a piggery, not mentioning the ducks and geese which afford the downy pillows. Utmost care is used in selecting seed for the gardens, and a scheme of planting is followed to meet the needs of the dietary department at various seasons.

Clean, well constructed stables, and separate milk rooms for handling the product are important in the production of "clean milk," which is defined as "milk that comes from healthy cows, is of good flavor, and free from dirt, and contains only a small amount of bacteria, none of which are harmful." No little satisfaction comes from serving country-made butter and buttermilk. Then, there is the necessary supply of cream, whole milk, and separated milk for cottage cheese, all of which form a large part of the dietary requirements.

The dairy herd numbers fifty Jersey cows, with an additional fifteen healthy calves. A veterinarian tests the cows for tuberculosis at least once a year.

The Rest Room is just what its name implies. It is a building 125 feet long, 30 feet wide, and

The Cannery and Picnic Tables in Kentucky Cozy Corner

12 feet high. Through the center is a manger at which the herd is fed and a mixture of cow chow, cotton seed meal, and bran; in this room the cows are bedded and rest until four o'clock every morning. After being fed and cleaned, they are taken to the dairy barn for milking.

The dairy barn is placed with its length extending north and south, so that the interior of the barn receives the most sunlight; approximately four square feet of glass per cow is provided.

The building is a two-story barn, in which the feed is stored on the upper floor. Accessibility for unloading hay and feed is very convenient without the necessity of having to drive through gates.

While the amount of cubic air space per cow in the stable is not necessarily an indication of good ventilation, about 850 cubic feet are allowed for each animal; and there is a special ventilating system designed to remove foul air.

The gutter and the floor are of concrete, so constructed because concrete is durable and may be kept clean with the least amount of labor and expense. The whole floor has a fall, from one end to the other, of about 1 inch to every 10 feet.

Two calf pens accommodate ten calves each, and plenty of space and light are provided for them. City water being available, there is never a shortage for necessary uses. The herd is watered at a trough outside of the dairy barn.

The milk house is at a distance of thirty feet from the barn and connected with it by a passageway. There are two rooms, one for the washing and sterilizing of the utensils, the other for handling the milk, which is properly cooled and stored. Cream is separated, cooled, and likewise stored. When sufficiently cooled, these products are delivered by truck, to the Sanitarium where they are placed in the milk department of the refrigerator to await consumption. The average daily delivery to the hospital is 35 gallons of whole milk, 5 gallons of separated milk, and 65 pounds of cream. Approximately 15 gallons of separated milk are fed daily to the calves, hogs, and chickens.

Another important service is the fattening of baby beeves and Hampshire creep-fed lambs. About one-half acre is enclosed for from eight to ten beeves, weighing on an average of 300 pounds each. Daily rations consist of a mixture of 6 pounds of corn, cotton seed meal, and hulls for a period of 90 days. Water is provided at a tank. At the expiration of this time, the weight of a beef will have been doubled, dressing down to about half. In round numbers, 12,000 pounds of dressed beef were delivered from the farm in 1936.

The raising of hogs is well worth while for the consumption of waste products from the kitchen. In return there are lard, ham, and other pork products, so popular with the nurses and hospital family. Patients, too, like country style meals occasionally.

The Cannery

Ownership of a farm makes it possible to "put up," not nearly all the canned goods required through the off-seasons, but enough to support the slogan, "One Hour from Field to Can." A remodeled garage is "The Cannery." It contains two well lighted rooms with concrete floors, shelves for jars and cooking utensils, gas stoves, necessary tables, chairs, and sinks. One room is equipped for the preparation of fruits and vegetables for canning; the other is for the actual

Scene at the Sanitarium Farm

work of preserving these products. Steam pressure cookers enable this miniature canning factory to get the high pressure used in commercial canning. The use of this cooker is an economical practice, even though an extra shift of workers is called in to do the canning. It has been possible to take farm products on accounts, and it has provided work for unemployed women throughout the summers of the past period of general unemployment.

Both the cook-in-the-kettle and the cook-in-the-can methods are used. The use of the tin can is preferred to the glass jar because it is more practical; there is less danger of breakage, less loss by spoilage, and it requires a shorter time for processing.

Machines are used for sealing the filled cans and for reflanging used cans that have been properly opened.

Bibliotherapy Department

Back in the early days of The Sanitarium of Paris there were a few books for patients to read. These were brought from homes, and in true pioneer spirit were shared with hospital neighbors.

As a matter of course, there grew with the passing years an eagerness for a hospital library. Dr. L. P. McCuistion, chief surgeon and medical director of the Sanitarium, prompted by compassion for lonely hospital folks, appointed a library committee, gave his check for a substantial amount, and asked this committee to organize a library which would have its shelves filled with the right tonics, sedatives, salves, and balms to match the conditions of the patients. In his instructions he advised that there should be included in this library cultural and recreational books for the doctors, nurses, and employees of the hospital.

The L. P. McCuistion Library

Charging Desk and Some of the Readers

The medical staff cooperated splendidly from the outset. This organization pledged fifty dollars a month for a period of two years, and individual doctors gave checks ranging from twenty-five to one hundred dollars each to help establish the bibliotherapy department. This library was known as The Sanitarium of Paris Library.

The business offices housed the sectional bookcases until it became necessary to care for the overflow in the halls. At this time printed book lists were kept in the chart rooms, and the nurses gave their wholehearted cooperation, bringing to the eager patients the cheer and comfort of therapeutic reading.

The spirit of the good neighbor continued to grow. On June 1, 1925, Dr. McCuistion's many friends pooled their resources and gave him a library as a pledge of their faith in the value of the library he had founded. They named it "The L. P. McCuistion Library," and presented it to him as "For-get-me-nots from Every Day Gardens" on the thirty-fifth anniversary of his first day's professional service in Paris.

Plans were then under way for the construction of the Annex, and provision was made for the inclusion of the new library. The amount of money pledged was sufficient to build and equip a reading room, stack room, and repair shop.

The reading room is furnished with art metal tables, files, charging desk, and adjustable shelves to care for twelve thousand books. Windsor chairs are used at the reading tables and easy leather chairs are provided for convalescent and leisurely

readers. The walls are tinted in soft green and rose shades, and the floors are made of rubber tile. Monks cloth curtains and bright colored drapes add to the cheerfulness of the surroundings. Nurses, doctors, employees, and visitors use the reading room.

Life memberships were issued in recognition of the interest, generosity, and friendship of those who made possible the privileges of this library. Teachers, students, club study groups, ministers of the gospel, parents, and children are daily visitors.

The end of the year inventory revealed that there were forty-three current magazines in circulation; the accession book disclosed that the library contained 8,029 volumes, covering every classification of literature.

The librarian has had three years of university education and is taking a correspondence course in library administration. She will be given a leave of absence to get her required work in residence. She gives daily book-wagon service to patients and also carries toys, games, puzzles, and materials for scrap books. Sometimes she tarries to tell a story.

Patients are not limited to one book at a time; neither are they fined for overdue books. Other readers are asked to pay fines and to pay for books lost.

In addition to the regular library service offered, the library sponsors an annual series of entertainments free of charge. These consist of book reviews, lectures, travelogues, and musical programs.

How is the library supported? Annual memberships, gifs, and fines are accepted. Dr. McCuistion, in his usual generously humane spirit, provides that there are no financial worries where the library is concerned. His Materia Medica and Materia Libraria are co-operating and co-ordinating references.

The Training School

The Paris Training School for Nurses was chartered on January 30, 1911, its organization calling for a board of trustees of five members, three of whom have given of their time and service to the present day. The school was located in St. Joseph's Infirmary temporarily, and later in the Aikin Hospital, until on April 12, 1914, it was transferred to The Sanitarium of Paris, its permanent home. At that time the school numbered ten students, who were given a course of instruction covering a period of two years and three months, this being lengthened to three years in 1923.

At the present time the school enrolls thirty-three students, with a full time instructress. The curriculum, as outlined by the State Board of Education, is followed closely. The educational unit includes a large classroom, an approved demonstration room, the nurses' library, and two offices, one for the superintendent of nurses, the other for the instructress.

The nurses' library, fitted especially for the students' needs and use, is within easy reach of the class room and contains four hundred seventy-three reference books.

The class room, known as the Mary McPhee Memorial Hall, can be converted into a general assembly hall and is fitted with the usual class room furnishings, including a life-size, fully colored, dissectible anatomical model.

Three courses of instruction—dietetics, psychology, and chemistry—are taught by Paris Junior College professors, other courses being given by staff doctors at afternoon classes, and remaining classes are held by the instructress.

Extra curricular activities include a weekly Bible Study half hour, morning chapel, physical education, and a glee club, organized in 1930.

In glancing back over the personnel records, we find there the "lengthened shadow of a woman," Elizabeth M. Hilf, R.N., superintendent of the hospital from the day its doors first swung inward until the gates opened outward for her on May 30, 1933. The wisdom of Miss Hilf's administration is revealed in every nook of the institution. Especially is it evidenced in the fact that there has been no change in the original personnel of the major positions except that caused by the hand of the Almighty.

Many positions have been held on a scale from 8 to 23 years, proof that the Sanitarium of Paris has been especially blessed in its freedom from cost of turnover in personnel.

On the board of directors are five of the charter members and the secretary. Their one thought throughout these many years has been, "Never turn a deaf ear to human suffering." And in keeping with this policy, the hospital has never turned away a patient for lack of funds.

This story ends with a regret: regret on the part of the contributor because she was not privileged to grow up with this hospital, year by year, since its beginning. Sixteen years is such a short time in the life of a neighborly organization!

Gone With the Flood

ALBERT G. HAHN, F.A.C.H.A., Administrator
Protestant Deaconess Hospital, Evansville, Indiana

AN UNFAMILIAR STEP is heard in the corridor of the hospital. It seems unusually heavy. It is the step of a doctor wearing his heavy hip boots, making his hospital calls after hours of Red Cross duty, helping and serving the hundreds of refugees from the states of Kentucky and Southern Indiana, who have been brought to Evansville, Indiana Red Cross stations after being compelled to evacuate their homes because of the flood.

The telephone rings. It is the Red Cross base nearest the hospital calling in regard to admission of a man who for a week has worked day and night in unselfish service with little sleep, and that with his clothing on his back. He is a business man, who, when the news of the great flood reached him, volunteered to give his money, time, and ability to help the victims who in most cases lost their homes, furniture, and clothing. The hospital admits him, weary and exhausted, to receive the necessary care to prevent that dreaded disease, pneumonia, which follows so quickly upon cold, exposure, and exhaustion.

On the lawn of our Deaconess Hospital a group of children gathered in front of the Clara Barton Memorial. This memorial to the founder of the American Red Cross, you may be surprised to learn, was dedicated on National Hospital Day, 1934, by the American Red Cross. It was from this site that she directed the work of the flood disaster in 1884.

The building which during this emergency was the National Red Cross Headquarters was purchased eight years later to become the first Deaconess Hospital with a capacity of nineteen beds. Now the 1937 flood has far exceeded the 1884 flood and practically two hundred victims are being admitted into the present modern Deaconess Hospital at the same site where the early flood relief was carried on. So, history repeats itself and the spirit of Clara Barton moves on as does the mighty current of our swollen Ohio.

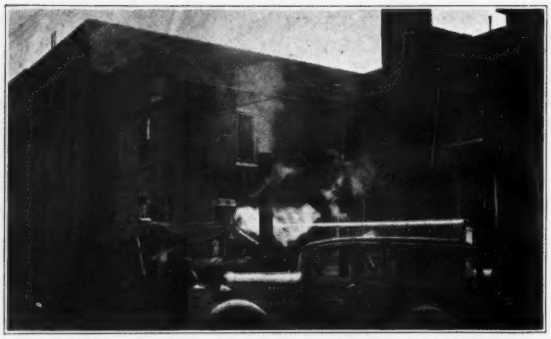
"Gone With The Wind" by Margaret Mitchell informs us that war, pestilence, flood, and famine bring a better understanding of the spirit of brotherhood and a stronger recognition of the power of God. "Gone With The Flood"—yes, our material possessions—now we find that the strong must bear the infirmities of the weak, and so the Protestant churches, Catholic community centers, Jewish temples, lodges, clubs, and the military forces all worked together in this great act of mercy.

The calm and peaceful Ohio River is on a rampage. The Ohio, normally one mile wide, has overflown her banks and inundated western Kentucky and southern Indiana, in many places covering an area twenty-five miles in width. Boats of every kind and description have been pressed into service and every lumber company is supervising the building of more boats to be used in the rescue of flood victims and live stock. The U. S. Coast Guard is here and has shipped to Evansville over two hundred boats for relief work. In addition, every truck, ambulance, motor bus, and passenger vehicle has been pressed into emergency service because the majority of the people refused to leave their homes. They believed that, since the water had never reached their homes before in the history of Evansville, it could not this time.

Never having experienced a water stage even within five feet of the stage this year, the citizens of Evansville could not realize that about one-half the city would be inundated. They could not be persuaded to leave their homes before the waters rushed in upon them.

Short wave stations were on 24-hour duty relaying important messages to the proper places. At three o'clock in the morning on January 26, one of the short wave stations picked up a message and relayed it to us that evacution orders were to be issued at daylight. Immediately, the hospital began to make plans to evacuate the patients. Our objective was threefold—first, safe removal of the patients; second, protection of property and moving of equipment to top floors; and third, safe evacuation of personnel. The response from the personnel was as it should be—those engaged in hospital work think of themselves last. Before the end of the day, the order was rescinded; the hospitals must remain in service to the last moment as suffering and illness must be cared for.

The new American Legion Home was equipped as a communicable disease hospital, especially for taking care of the cases of scarlet fever which are so prevalent at the time of a flood. Each Evansville hospital increased its bed capacity thirty per



Improvised boiler placed in the alley and used to heat the Welborn-Walker Hospital when the flood completely incapacitated the heating plant of the public utilities company.

cent in order to take care of the increased demand for hospital care. Many former graduate nurses, no longer in active service, were called from their homes to meet the emergency.

Each hospital had its own peculiar problems and here is how they solved them—

St. Mary's Hospital

Here is the story of how St. Mary's Catholic Hospital met the emergency as told by Sister Dolores, superintendent:

"On Monday, January 25—City water shortage was experienced, the mains being shut off, and opened only twice daily.

"Tuesday, January 26—Water was promised from 7:00 to 7:30 a. m. and 7:00 to 7:30 p. m. but none reached the hospital. By Tuesday evening there was no available drinking water. An appeal was sent out and Mr. C. W. Schnute of Citizen's National Bank sent a supply of pure water.

"Wednesday, January 27—Cook's Brewery and Sterling Brewery supplied drinking water, and for domestic purposes water was brought in Standard Oil Tanks from Terre Haute and nearby cities.

"Thursday, January 28—Borden-Wieland Milk Trucks began delivering water twice daily for cooking and drinking purposes, bringing it in from Indianapolis. The Red Cross Water Administration donated fifteen glass containers of distilled water for surgical, laboratory, or drug purposes.

"Surgeons reduced the number of operations to the minimum. Water shortage was not felt in the surgical department as there are special reservoirs in the attic to supply such emergencies. Sterilizers are so constructed as to meet all requirements as usual.

"Following orders of Board of Health, all water used for drinking, cooking, or washing dishes was boiled for twenty minutes. Milk, likewise, was boiled for twenty minutes until that restriction was withdrawn.

"To further compliance with Regulations of Board of Health, the entire personnel was immuned against typhoid fever."

Welborn-Walker Hospital

Nearer the river we have the Welborn-Walker Hospital and Dr. James Y. Welborn relates how

When the city water works plant failed St. Mary's Hospital supplemented the supply of water from a small well on the property by drilling another well.

his institution met the most unusual conditions as this hospital had more physical handicaps to overcome.

"The Welborn-Walker Hospital located at Fourth and Oak Streets in Evansville, Indiana, was early affected with water in the basement. Our heating for hot water was located there and was soon flooded. The heating system for the hospital is through the Public Service Company and was not put out of commission the first few days of the flood; however, it was later. In the meantime, we secured two large boilers, which were put on the surface in the street. We have had sufficient heating in the hospital throughout the entire time. The elevator system did not go out until the water had reached its crest; it has not interfered with us very much. The telephone system went out when the conduit in the basement filled with water. We now have new telephones installed and they take the place of the other phones.

"In the meantime, we have increased the bed capacity twenty-five per cent and have taken care

of all the workers and physicians about the hospital without any great inconvenience. The height of the flood covers about one-half the streets about the hospital.

"The capacity during the flood has been 135 beds."

Protestant Deaconess Hospital

On the morning of January 23, we received the news that during the night the waters of the Ohio had rushed in and suddenly inundated much of the city. An emergency call was sent to our personnel and everyone was pressed into service to protect the property and to care for the patients who that morning were rushed into the hospital. Additional beds were hastily set up, single rooms were made into double rooms, the nurses' training school division located in the hospital building was turned into a large ward, beds were placed in the waiting rooms and in every other available space.

The Deaconess Hospital was well supplied with household supplies, foods, bedding, and drugs as we had previously purchased large quantities because of the advancing market of all commodities; so we were prepared to render the best of hospital care to all patients. We were never without lights, heat, and power. The principle handicap arose when the flood damaged our city water plant thus cutting off our city water supply. What to do to meet this emergency was the question. First, our deep well was pressed into service; however, it was necessary to supplement this supply with additional water for our high and low pressure boilers. Three trucks were secured to supply water for the hospital—one truck with a 3000 gallon capacity tank hauled water from the deep well of the Indiana Briggs Corporation; one hauled water in barrels for sanitary purposes; and one hauled drinking water which had been approved by the Board of Health. However, every precaution was used so we boiled all drinking water twenty minutes. The problem of sanitation presented a major problem. To meet this handicap, thirty men were engaged—three shifts of ten men on each—to carry water to the utility and toilet rooms. These men were responsible for destroying all waste and offensive odors. This work was done most efficiently.

Nurses' home, Welborn-Walker Hospital, showing long heating pipes extended from the utility heating system to the home.

All of the large refrigerators in our main kitchen are water cooled; so when the city water was cut off, the Servel Refrigerator Company immediately sent their technicians to the hospital to install a fan and humidifier in the window thus changing the refrigerators from water cooled to air cooled and enabling us to keep our food cold and preserve our large supply of perishable foods.

As a precaution electric and gasoline pumps were set up in the boiler rooms ready to be put into action immediately if the back waters in the sewers would come into our boiler rooms, but fortunately this never occurred as we are located on the highest point, geographically, in our city. Many places were without heat and power including our leading hotels.

To prevent a typhoid epidemic all our personnel were given three injections of typhoid anti-toxin —one each week for a period of three weeks.

Sleeping accommodations were provided for our maintenance staff so as to be prepared to meet all emergencies, and our entire executive staff remained constantly on duty at the hospital to direct increased activities. A noble group these hospital workers and they should receive the highest commendation for their loyalty and unselfishness.

Red Cross nurses, administering typhoid vaccine, as recommended by the Board of Health.

A new type of service was instituted in our hospital during the flood—a radiogram operator was on duty at the radio receiving set recording all orders and bulletins pertaining to the hospitals issued by the Red Cross and Military Headquarters. For example, here are two of the radiograms received—

"Three ambulances are leaving Red Cross Station No. 4 for the Deaconess Hospital."

"To all doctors in Evansville: Please report daily before 11:00 a. m. all of the following diseases at the Board of Health. The diseases are: chicken pox, diphtheria, influenza, measles, mumps, scarlet fever, small pox, typhoid fever, whooping cough, pneumonia. Signed, Dr. Thomas F. Reitz, Secretary, City Board of Health."

Due to the fact that the Protestant Deaconess Hospital has been broadcasting a daily religious service since 1925 we were in a position to cooperate with the Red Cross and the Military authorities, relinquishing our time to them. Our broadcasting consists of the Sunshine Hour each afternoon at 3:00 o'clock for a period of thirty minutes, the Sunset Hour on Tuesday from 2:30 to 3:00, the Friendship Hour on Wednesday from 2:30 to 3:00—these programs are all of a religious nature. On Thursday from 2:30 to 3:00 we sponsor musical recitals given by the Cluthe Studios of Music. Also, on Monday, Wednesday, and Friday morning we have a Health Educational Broadcast and this time also was used to broadcast Red Cross and Military bulletins. We were very happy that we could contribute these periods of broadcasting. It was appreciated by all those engaged in the Red Cross work.

All hospitals were confronted with this problem—many patients who had been brought to the hospital from their flooded homes did not have sufficient clothing when they were ready for dismissal. Many had been removed from their homes by boat and at night and possessions could not be moved because space was too valuable. Before we could dismiss these patients, clothing had to be obtained from the Red Cross.

Red Cross Nurses

Two Red Cross nurses, namely Miss Senji Mikkola and Miss May O'Malley from the Grant Hospital, Chicago, visited every victim hospitalized. They report their opinion of how the hospital and nurses met the emergency—

"Fifty-two registered nurses from Chicago were sent to the flood relief area with Miss Amy Chamberlain in charge. We arrived in Evansville at 10:00 p. m., Monday evening, January 25. We were met by the Red Cross officials from the National Headquarters and in a few days most of the nurses were sent to different points on the river where nursing aid was most needed. Some were sent to refugee camps in the city of Evansville to help care for the sick and to administer typhoid anti-toxin. Our group was appointed to make surveys of the hospitals in the city and take records of all cases hospitalized suffering directly or indirectly from the disaster caused by the flood.

"Although impatiently waiting to be sent to more distant points where suffering was more keenly felt, we found our work very interesting. The hospitals were crowded to capacity but in spite of this, emergencies were met with the greatest efficiency and calmness. We were confronted with many personal requests from the patients concerning their relatives and their whereabouts. These requests were taken to the local Red Cross Headquarters where they were promptly broadcast over the radio.

"Patients were very glad to give all the information they could and were ever so thankful for the kind and courteous care received, and in all cases could not praise the Red Cross highly enough for the many services received from the organization."

The following is a statement from Robert Knight, National Headquarters publicity manager—

"Red Cross conscription of nurses throughout the country for disaster relief work along the Ohio and Mississippi River valleys will perhaps go down in the annals of the nation as the great-

Canoe Ambulance in front of the Welborn-Walker Hospital

est organization of medical resources since the World War.

"Since the day angry waters of the Ohio began a march of destruction toward the Mississippi, a call originated by Admiral Cary T. Grayson brought nurses from all parts of the country. Every means of transportation was employed. Women with Red Crosses on their arms took planes, trains, automobiles, and boats—any way in which the factor of speed could be emphasized. Sometimes unable to reach their destinations because of high water, breath-taking experiences arose. Listen to the story of three Red Cross nurses who spent a fitful night aboard a Coast Guard patrol boat in the muddy currents of the Ohio.

"We left Newburgh, Indiana, for Owensboro, Kentucky, at 3:30 in the afternoon. The river was reaching its crest and the thermometer was dropping with alarming rapidity. Our boat headed to the east, nosing into the current. The cold water broke over the bow, sending a cold spray into our faces. As darkness fell the captain in charge of the boat told me we were progressing at approximately two miles an hour. Twelve hours later we reached Owensboro. The situation was distressing. As we landed a group of men met us at the shoreline. We immediately rushed to a refugee center which the local chapter of the Red Cross had established. We quickly organized an emergency hospital, and—for two sleepless nights—inoculated and treated scores of flood sufferers. I will never forget those two days."

"Scenes similar to this Red Cross nurse's experience recurred daily along the restless flood front as approximately 1000 nurses fought their way to inundated areas. For the most part nurses were drawn from hospitals, forsaking the comforts of the city to serve the Red Cross in working among a million flood-panicked persons. Admiral Cary T. Grayson, National Chairman of the Red Cross, at Washington praised the generous cooperation of the hospitals of this country in depriving themselves of large proportions of their nursing staffs. "Without the services of these nurses," Admiral Grayson said, "it is dubious that the splendid standards of health maintained throughout the flooded region could have been upheld."

Ten Days of Flood

Many ask the question "How does a flood rush in upon a city so quickly?" Here is the answer of how it rushed in upon Evansville in the following summary of ten days of the flood.

January 21—Forecast of 47.7 stage issued as river reached 45.2 at 1 p. m.

January 22—Record flood expected. Weatherman Collon said "Prepare for at least 51 feet." At 1 p. m. it was 47.4. Sleet and snow stopped street car service.

January 23—The 1913 record equaled before 1 p. m. when the river reached 48.4. Red Cross substations and contagious disease hospital set up.

January 24—Martial law declared. Colonel Louis L. Roberts, 139th Field Artillery, Indiana National Guard, in charge. Weatherman McLin S. Collom died in his office after working strenuously for hours at the U. S. Weather Bureau—this was just one of the tragedies of the flood.

January 25—Colonel Roberts issues military rules, limiting gasoline and coal. About 300 blocks under water.

January 26—River at 1 p. m. reached 52.24 rising slowly. Business, except providing relief needs, suspended by military. Waterworks shut down.

Another way of transporting patients to the hospital

Break in main well blamed. Telephone service limited. Electric power shut off in flooded areas.

January 27—Drinking stations established. Tank cars sent supply to the city. Water rationed from reservoir one hour daily. Coal purchases, formerly limited to five bushels, raised to 25 bushels. Over 400 blocks under water in Evansville.

January 28—Hundred men start attempt to repair waterworks. Break found to be less serious than first feared. Red Cross announces plans for rehabilitation program. Warnings to boil all water and unpasteurized milk issued. Red Cross Chairmen Paul Schmidt and Philip Drachman, disaster relief chairmen, rescued when boat collapsed. Last bridge to West Side closed.

January 29—Citizens Rehabilitation Committee made plans to renew business. Damage to Waterworks partially repaired. Evansville-Henderson bridge approach south of city found to be creating strong current in East Side and inundating many of the better homes because of this natural water shed.

January 30—Crest of 53.74 feet reached. Over 500 blocks under water in Evansville. No one permitted to enter flood area by military officials. Furniture, clothing, et cetera remaining in flooded homes. virtually destroyed.

It is difficult for those who are away from the scene to visualize some of the things that occurred along the banks of the Ohio—people clinging to the roof-tops of their homes, praying not to be swallowed up by the muddy, swirling waters; refugee camps filled with people hungry, cold, and sick; a mother with her newly-born child, frozen to death; two eight-year-old boys waiting in water and cold for parents who might never come back; a WPA rescue worker drowned trying to save a life; a faithful dog shot to death when he refused to let soldiers save his marooned master and mistress; a firemen standing stiff and dead, his hose still in his hands.

Doctors and nurses were on duty day and night, caring for the sick with serums and vaccines; WPA and CCC men everywhere proved heroism beyond description; the police were helping and protecting; firemen waded neck-deep in water and mud to save the stranded from being burned to death; drug stores and restaurants were open twenty-hours a day; radio staffs were almost dead from lack of sleep, worried about their own dear ones, and doing the greatest piece of work radio has ever seen.

Especially to be mentioned are the homes and the cities which not only sent food, clothing, medicine and money, but also took in thousands of the evacuated from the inundated areas. Forgotten were all differences of color, nationality, and religion. Remembered only was that human beings were brothers and sisters under the skin, and in desperate need. The story of mercy and human brotherhood will long remain to prove that in the United States we are one people. This is the golden, happy lining of the blackest cloud our nation has ever known.

Soon the turbulent waters will again be quiet. Now, the work of rehabilitation begins, care must be given the sick and dispossessed. It means bravery and determination.

As impressed as I have been with the sorrow and suffering, I cannot help but see also that out of the great trouble has come a great light. Human nature rose to supreme heights.

How the Flood Came to Cincinnati Hospitals

WALTER E. LIST, M.D., Superintendent
Jewish Hospital, Cincinnati, Ohio

THE flood of 1937 will go down in history as one of the most devastating catastrophes occurring in the Ohio Valley. The freakish weather conditions brought us in mid-winter, days of maddening, monotonous rain, and by January 24, the precipitation grew to the alarming figure of more than twelve inches. At three o'clock on this day, the flood stage was 72.8, and the water was rising at the rate of a tenth of an inch an hour. Warnings sent out by the press and radio told us that the flood water had struck a vital point in our existence—the Waterworks Department was threatened, and the pumps could hold out for only a couple of hours.

The ravaging element creating so much havoc in the lowlands created now a menace to the hospitals located on the hilltops in Cincinnati. Our normal operation was in imminent danger. Water, heat, power, sanitation, refrigeration, all presented problems, problems which came upon us before we had time to work them out. The inevitable happened. The water ceased flowing, and our hospital was in total darkness.

Our first move was to send out an emergency call for water to Dr. H. H. Langdon, acting superintendent of the Cincinnati General Hospital, who was in charge of all emergency requests made by the Cincinnati hospitals. Dr. Langdon furnished us with an initial supply of three thousand gallons. Independent emergency crews were formed immediately to handle the water situation in all its branches within the hospital.

One crew handled entirely the water used in our boilers. A large tank wagon was connected with the union to the blow-off in the boiler. A boiler not in use was kept filled with water which was run through the pumps. In this manner we were able to generate sufficient amount of steam to obtain light and power. When the water in the tank wagon was emptied another tank wagon was connected to the blow-off immediately. This procedure was followed throughout the twenty-four period of each day. Our heating, power, and light problems were thus solved.

The drinking-water crew distributed drinking water from the point of receiving to the various destinations throughout the hospital. In order that the water be kept fresh, this was done on a regular hourly schedule.

Another crew was assigned to furnishing water for toilets and clinic sinks. A fifty gallon barrel, which was kept filled with water by this crew, was placed in each toilet room.

In the operating room, our sterile water containers were filled with water by hand.

Our drinking water was supplied by artesian wells within the city limits and from the neighboring suburbs. Distilled water was furnighed by a local beverage house. All other water was received from distant cities.

During this entire period, water was used for no purposes other than as designated.

Our laundry problem was solved through the aid of the Cincinnati Milling Machine Company and the American Laundry Machine Company. An emergency laundry was set up in the plant of the Milling Machine Company, which was able to supply water from its own artesian well. The American Laundry Machinery Company installed a washer and extractor. Our linens were washed and extracted by our own labor and brought back to the hospital for mangling and finishing. This service was used by the other hospitals in Cincinnati, each institution having certain hours set aside for its work.

To obtain ice, a truck was sent daily to Hamilton, Ohio, a distance of about twenty-two miles.

Much credit is due to the business firms who helped, by furnishing labor and transportation, to see us through this great emergency, and to our own loyal force who labored night and day. How well they served is attested by the fact that from chaos sprung order which settled down into a mere routine of many tasks well done.

Massachusetts General Hospital to Build a Fifteen-Story Hospital Building

Dr. N. W. Faxon, medical director of the Massachusetts General Hospital advises that a new 15-story, $2,000,000 building will be constructed at the Massachusetts General Hospital if city officials will agree to waiving zoning laws for that section.

An application for a permit to erect the proposed structure, which is to be known as the George Robert White building, has been filed at City Hall by hospital authorities.

The new building is to be located in the center of the hospital grounds, bounded by Allen, Blossom, Fruit, and Charles streets, and will be used for general hospital purposes, according to present plans.

It will be 188 feet high and will have fifteen floors, with four setbacks. It is to be constructed of brick and stone. The main entrance is to be 150 feet in from Fruit street. On the ground floor the building will have a 160-foot frontage and a depth of 180 feet.

Wings will be constructed at each end of the building. Because of the four setbacks, the amount of space will vary on different floors. The first floor will have 25,000 square feet of floor space, the second will have 17,000 square feet. The third to the sixth stories will each have 15,000 square feet. The seventh to the twelfth floors will have 13,000 square feet, and the thirteenth to the fifteenth will each have 9,000 square feet.

The firm of architects which is drawing up plans for the proposed building is Coolidge, Shepley, Bulfinch and Abbott.

Role of the Hospital in New Nation-Wide Venereal Disease Control Program

REGINA H. KAPLAN, R.N., M.A.C.H.A., Administrator
Leo N. Levi Memorial Hospital, Hot Springs National Park, Arkansas

THE REVIVED INTEREST for the control of venereal diseases was the occasion of a conference recently held in Washington at the call of Surgeon General Thomas Parran, Jr., of the United States Public Health Service. Over 500 representatives, from all parts of the country, were present at this conference.

In recent months the subject of venereal diseases has been placed before the public to an extent never before known in this country. From the trend of scientific articles, appearing recently in popular periodicals and leading metropolitan newspapers, it appears that this subject will occupy a major position in the medical field for some time to come. It, therefore, seems necessary for the hospitals to take cognizance of this situation, investigate their shortcomings, and prepare to take their place in this new program.

Past Attitudes

In the recent conference it was again emphasized that the chief stumbling block in the control of these diseases is the silence, prudery, and ignorance with which the subject has been surrounded. Heretofore, at least, the greater portion of the lay public has believed that venereal disease existed only in the lower stratas of society and it was not considered possible by otherwise intelligent persons that these diseases might exist among their own associates. Most unfortunately, this fallacy was present also in the medical profession. Unless occular evidence is present venereal disease is not suspected by the average physician and examinations for these diseases are not made routinely except by those who have had special training in this field. Prejudice has existed to such an extent that hospitals have refused to accept a known venereal case and comparatively few of these institutions make routine examinations for these diseases in all admissions.

Present Day "Hospitalism"

We may say, then, that the present faults of the hospitals are a lack of awareness of the situ-

Leo N. Levi Memorial Hospital

ation and prejudice. Our lack of understanding in this matter is comparable to the conditions of the nineteenth century when ignorance was largely responsible for the condition first described as "hospitalism" by Sir James Y. Simpson in 1869. Sir James used this term to describe "the hygienic evils which the system of huge and colossal hospital edifices created." Using the best knowledge of his day, Sir James advocated cottages, to contain not more than two people, made of iron instead of brick or stone, rebuilt every few years, to overcome the evils of his time. It was his opinion, based on the knowledge of his day, that large hospitals were responsible for many deaths.

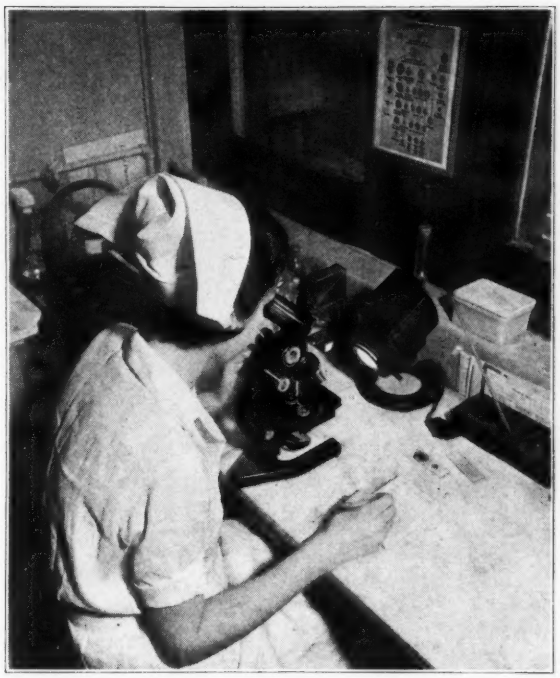
In 1874 Doctor Erickson used the term "hospitalism" to describe the general morbid conditions of the hospital buildings and their atmosphere, productive of disease. He contended septic conditions were aggravated in a hospital and should be treated in private homes. He advocated destroying a hospital if it become "pyemia stricken."

The same idea was advocated in America, following the Civil War, and it was recommended that wooden sheds or huts be built for hospital purposes because they were more easily and readily disinfected or destroyed, if necessary. It was a generally accepted fact at that time that hospitals *killed* more than they *cured* and the remedy advocated was not more than two patients in a hut or tent.

Then Lister and Pasteur introduced the germ theory and proved that the size of the building was of no importance or significance when antiseptics were employed. The word "hospitalism" lost its significance and fell into disuse. The modern hospital had come into being.

Many new developments have since been presented to the hospital both in the field of medicine and the material comfort of the patient. Today in the United States we have some of the finest hospitals in the world and we have gained the confidence of the public at large. We look with amusement and pity on the erroneous ideas of the dark era of "hospitalism."

Nevertheless, in the midst of all our grandeur and (sad to say) in the presence and possession of scientific knowledge, we permit a condition to exist which will be regarded by the more broad-minded and fact-facing future generations as "hospitalism" is by us today. I refer to the fact that two very serious and disabling preventable diseases have been permitted to become widespread in our population—not because modern medical science lacks the means to combat them—



Examining Slides

but only because we have been too cowardly and fearful of adverse public opinion to broach the subject and treat it in the same matter of fact way that we approach the problem of other diseases. In this the hospital, with other agencies of medicine and certain social attitudes, must assume its responsibility.

We speak of our institutions as "modern" hospitals and the patients who enter our doors rightfully expect and believe they are receiving all that modern medical science has to offer. In spite of this we neglect to utilize and deprive the patient of the benefits of some of the greatest achievements of modern medicine when we shut our eyes to the prevalence of the venereal diseases in our population and fail to consider their presence routinely in the patients who come daily to our attention. Present day statistics show that ten per cent of our population are infected with syphilis. The estimates for gonorrhea are even higher. When it is considered that these infections, especially syphilis, become chronic illnesses, producing a variety of symptoms suggestive of other conditions, the importance of routine examinations for these conditions becomes apparent.

In substantiation of this statement, I should like to offer the following data from our hospital records.

Procedure at the Leo N. Levi Memorial Hospital

The Leo N. Levi Hospital, with its component part, the Charles Steinberg Clinic, is situated at

A Corner of the Laboratory

Hot Springs, Arkansas. This institution is a private, eleemonsynary, hospital and clinic, maintained by the National Jewish Order of the B'nai B'rith, Jewish federations, and contributors from all over the country. Patients come from all sections of the country, suffering with all conditions known to medicine. They are attracted by the reputation of the Hot Springs hot waters, the fact that free medical care is not available at home, or because they have exhausted their resources, without benefit, in medical care elsewhere.

From 1914 to the present every patient who has entered the Leo N. Levi Hospital or Charles Steinberg Clinic has received a routine examination for venereal disease, treatment, if necessary, and follow-up service. Every member of the staff is on the alert for these infections and takes more than ordinary precautions in obtaining a possible history of these infections.

We have reviewed 10,500 records of patients admitted to the hospital proper and find that 271 patients, or 2.6 per cent, who entered the hospital with other diagnoses, presented a positive Wassermann in their routine examinations. Roughly divided, this group showed 131 medical and 140 surgical cases. In the medical group we find acute and chronic illnesses, ranging from mumps to cardio-vascular disease. In the surgical group we find everything from acute abdominal conditions to goiter.

It is true, of course, that the majority of the small percentage of patients with acute illnesses had their first hospital experience when they entered our institution. It is, therefore, understandable why these important examinations had not been made previously.

The majority of these patients, however, were in a state of chronic illness and had received medical care, over a period of years, from private physicians and in other hospitals and clinics, where modern laboratory facilities were available, without a serological test for syphilis having been made or this infection having been suspected. It is true that in some cases the syphilitic infection existed in addition to the illness which brought the patient to the hospital but it is also true, in the case of many others, that late luetic degenerative processes in organs or joints was the underlying cause of their present disability. If these patients had been examined for venereal disease earlier in their medical experience and proper treatment had been instituted the late manifestations might have been avoided.

In view of the fact that examinations to uncover such infection and efficient and effective treatment methods to combat it are known—but were not employed—and in consideration of the disabling effects of this disease, known as the "Great Destroyer," might not those who cared for these patients previously be said to have failed in their duty to their patient?

Generally speaking, cases admitted to this hospital with their pre-working diagnosis are the same as admitted to any other hospital. We do not believe the percentage of positive cases uncovered in our routine examination are in excess of what might be found in other institutions if the same procedure were followed. Here we are simply looking for trouble and we find it. The chief value of the tabulations presented is not in the statistics derived, but in the fact that infection was uncovered in this number of previously undetected cases and proper treatment instituted for these patients. To this extent we have given improved service over other institutions which did not employ this routine examination.

Particular attention is paid to prenatal cases in this hospital and all such patients are checked periodically during the entire period for the presence of venereal disease. Although a single examination may be negative one must always keep in mind the possibility of a subsequent infection.

When an infection is uncovered, the hospital does not feel that its responsibility ends with the discharge of the patient. When treatment is terminated here patients are fully advised concerning their condition and are encouraged to report to their physician at once. Patients who do not have a private physician are directed to

the proper health agency of their home community and are instructed to request the physician to write for a report of their case. The hospital service is thus two-fold; to the patient in the hospital and follow-up of the patient after discharge.

To complete our program, such examinations are not limited to the patient admissions only but include all personnel also. Particular stress is laid on those in the food departments. Every candidate for the training school must submit such report in her medical examination. We feel these preventive measures are not excessive when the dangers are considered which may arise when such precautions are not taken.

We do not favor the policy of restricting admissions when venereal disease cases are in need of hospital care. There are some hospitals which are hesitant and reticent in admitting such cases into their institution. Whether this is due to fear of dissemination of infection, to prejudice, or to fear of public opinion, I am unable to say but I do not feel that these are legitimate reasons for refusing hospitalization to a patient in need of such care. From a medical standpoint, these cases are no more dangerous than any other case of communicable disease and should be cared for on the same basis. As for prejudice and fear of public opinion, how can we make discrimination in illness? Is it not the function of a hospital to care for the people who are ill and in need of such attention? Would it not be just as logical to refuse to accept a patient severely injured in an automobile accident because of driving while intoxicated?

Solution of the Present Situation

In the solution of the present situation it must be taken into consideration that the hospital is, to a certain extent, limited in the scope of its services by outside agencies. This is particularly true in private cases, as in such instances the physician will generally outline the laboratory tests he wishes made. In view of this fact it is up to the hospital to educate the physician. This suggestion is not made in a disparaging manner and it is not my intention to revolutionize hospital procedure. I have endeavored to show, however, from our own experience, the importance of routine laboratory examinations for venereal disease, which contribute not only to the welfare of the patient but raise the standard of hospital and medical service.

I believe that the hospital should definitely encourage the incorporation of such routine examinations in hospital procedure. Since these diseases are so widespread in our population and are often found where least expected, this is only providing the patient with the service he rightfully expects when he enters the hospital. Thanks to the requirements of the American College of Surgeons all hospitals in good standing must be equipped with complete laboratory facilities. With these already existing facilities the performance of the simple tests suggested would not entail any additional expense.

The present publicity attending this campaign will speedily educate the general public to the importance and necessity of these examinations and hospitals and physicians should be alert to meet the demands which will arise, once the public becomes aware of the extent and seriousness of the venereal diseases. It must be remembered, however, that the hospital can accomplish little without the help of all concerned.

Summary

1. There is at present a new appreciation of the venereal disease problem in this country.

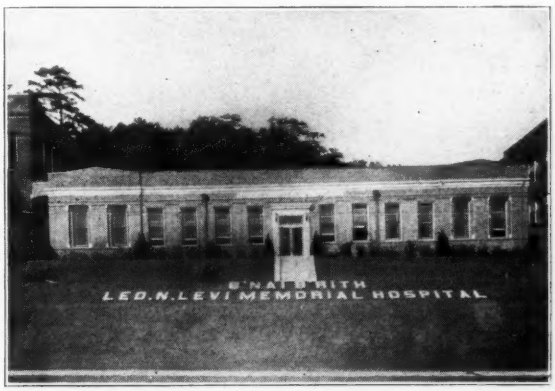
2. The indifference and prejudice with which this problem has been regarded in the past can no longer be maintained.

3. Experience at the Leo N. Levi Memorial Hospital, where routine examinations for venereal disease are made, indicates that a number of previously unsuspected and undetected cases may be uncovered by such routine examinations. This hospital also believes that such examinations should be extended to all personnel.

4. It is believed that venereal disease patients should be admitted without prejudice, when in need of hospitalization, on the same basis as any other case of communicable disease.

5. In the interests of better hospital service it is recommended that examinations for venereal diseases be made a routine part of hospital admission examinations.

6. With the increased appreciation of the



Charles Steinberg Clinic

prevalence and ravages of these diseases and with the diagnostic and treatment facilities available the control of these diseases is entirely possible, provided all agencies cooperate to this end. Let us hope the hospitals, with their great desire to be of the utmost service to the public, will accept their responsibility in this matter as they have their other responsibilities in the past.

Josephine E. Thurlow Retires as Superintendent of Cambridge Hospital

The Cambridge Hospital, one of the best known and one of the oldest of the Massachusetts hospitals, supported wholly by private funds, will change its administration on the first of March. Last fall the present superintendent, Miss Josephine E. Thurlow, presented her resignation to the Board of Trustees, who requested her to withhold this resignation until they should be able to find a suitable successor and entered the following minute upon their records:

"In accepting the resignation of Josephine E. Thurlow as superintendent of the Cambridge Hospital the Trustees desire to record their deep appreciation of all that she has accomplished for the Hospital.

"When Miss Thurlow first became superintendent, the hospital was little more than one building inadequately equipped for hospital work. Before and during the campaign for funds with which to build and equip a hospital adequate for the needs of Cambridge her zeal and enthusiasm and her determination that the Cambridge Hospital should be among the best took her to many parts of the country to visit and inspect hospitals and confer with those who were experts. She thus added to her already broad knowledge of hospitals and hospitalization and gave to us the results. It was upon her advice that the Trustees largely relied not only while building the present enlarged and adequate plant with its many new departments but also in creating the organization to carry it on.

She has organized and carried on a very efficient Nurse's Training School that has trained not only nurses but hospital superintendents.

Miss Thurlow has become one of the outstanding women superintendents in the country. At all times she has been determined that the Cambridge Hospital should be at the front in adopting new and improved methods. During her administration the hospital has for the first time been approved by the American College of Surgeons.

She has always taken a commanding position among her associates outside the hospital having taken a leading part in the Women's Hospital Superintendent Association of Greater Boston. She is a member of the Massachusetts State Board of Registration of Nurses."

In appreciation of her nineteen years of faithful and efficient service in the development of the hospital and of its school of nursing, the Trustees have voted to Miss Thurlow a retirement annuity.

Governor Hurley Appoints Miss Thurlow Chairman of the Board of Trustees of Boston State Hospital

Upon her retirement as superintendent of Cambridge Hospital, Governor Hurley appointed Miss Thurlow Chairman of the Board of Trustees of the Boston State Hospital. This is a State Institution for the care of mental patients. It provides care for 2300 inmates and is one of the largest institutions of its kind in this country.

In selecting Miss Thurlow for this important position, the Governor took into account her wide experience in hospital administration and her superior qualifications for the position. Miss Thurlow will assume her new duties on April 15.

During prom week-end, the dean of a Middle Western medical school was rudely awakened by the ringing of his telephone. It was about three in the morning; it must be an important call. The dean asked drowsily: "What is it?"

The voice said: "Dean, we need your help over at our house. We're having a party and Frater Jones has us all worried."

"Well, why call me? Is he seeing elephants and snakes and things?"

"No, that's why we called. The room is full of them and he can't see any."

Presbyterian Hospital Saves Heating Cost by Switching to Gas

ASA S. BACON, Superintendent
Presbyterian Hospital of the City of Chicago

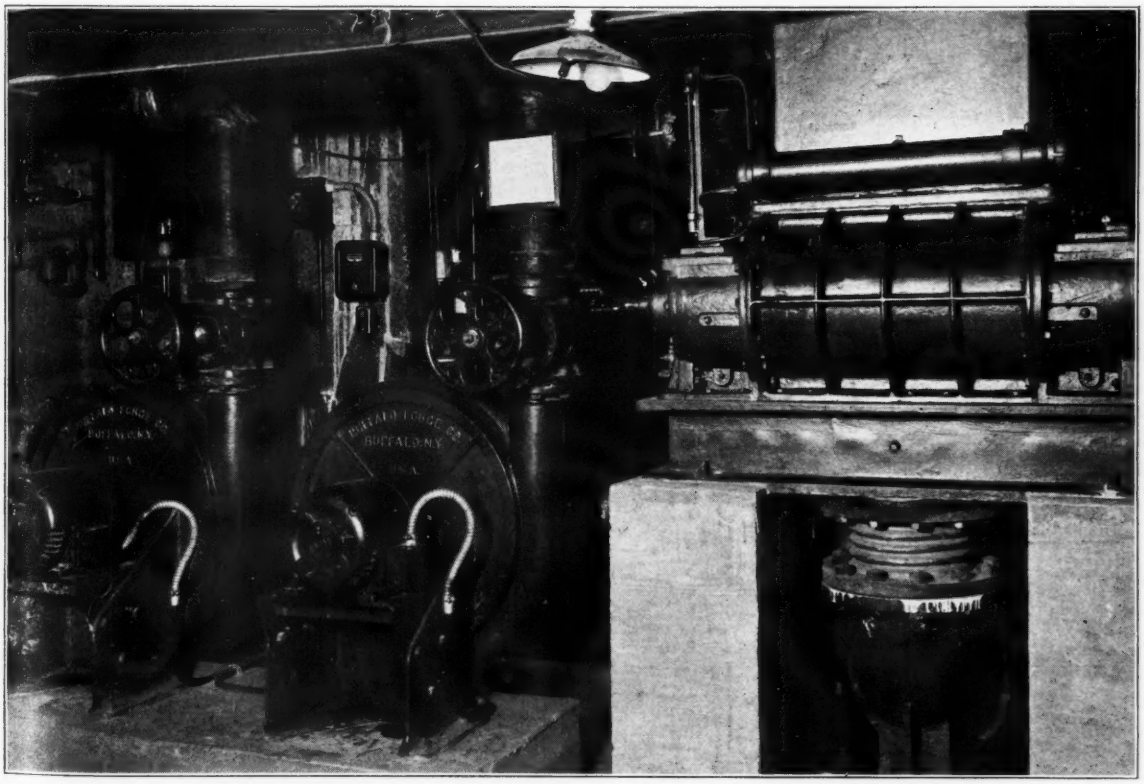
IN VIEW of the increased interest in the hospital field in the problem of fuel costs, as evidenced by the appointment of a special committee of the American Hospital Association in 1936 to study the fuel and heating equipment problems, the experience of the Presbyterian Hospital of Chicago, may be particularly interesting.

The hospital's heating equipment consisted of four Stirling type boilers, three of which were of 212 h.p. each, and one of 300 h.p. Each boiler was fired with coal by a chain grate stoker, the type of coal used being 1¼-inch Indiana Screenings. These boilers supplied steam at 100 lb. pressure to heat the hospital buildings, to supply the hot water, to operate the refrigeration, and the laundry machinery. Steam is also used for cooking in the main kitchen and diet kitchens, for sterilization, and for operating some of the elevators.

The chief objection to the use of coal was that the dirt and dust made it difficult to keep the rooms clean on the side of the hospital where coal was unloaded. In addition, patients on that side of the hospital often complained of the noise made by the coal and ash trucks.

There were two other types of boiler fuel available, gas and oil. After careful consideration and study, it was finally decided to use a combination of both fuels.

The three old 212 h.p. Stirling boilers were replaced by two new water tube boilers, each having a heating surface of 2,804 square feet and designed for a 200 lb. working pressure. The 300 h.p. Stirling boiler was completely overhauled.



The gas meter is at the right of picture. At center and left is the booster or pressure pumps. Only one is used, the second is held as a reserve

This shows the old installation (one boiler)

Thus, the present equipment consists of three boilers, each one being capable of developing 200 per cent of rating. This furnishes ample capacity to take care of present steam requirements, as well as all planned expansions and additions to the hospital plant. Space is also left for the installation of a fourth boiler in the event that future demands make this necessary.

Combination Gas and Oil Burner System

The boilers are equipped to use either gas or oil by means of a combination gas and oil burner system. This consists of three burners installed in the front wall of each boiler. Each burner is made up of a series of cylindrical refractory mixing tubes into which several streams of gas are forced under pressure varying from three ounces to twelve ounces. The streams of gas meet at a central point in the mixing tubes where they are broken up and intimately mixed with the cores of entrained air. Firing of this intimate mixture takes place at once, resulting in complete combustion with a minimum of excess air.

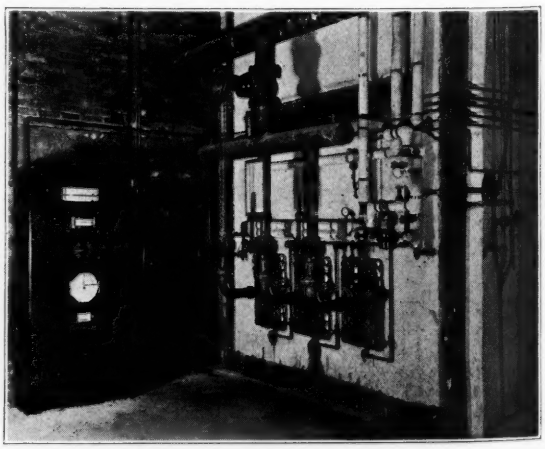
The gas, which is a mixture of natural and manufactured gas, and has a heat content of 800 B.T.U.'s per cubic foot, is brought into the boiler room building through a twelve-inch street service. This is reduced inside the building to a ten-inch welded line which runs to the gas meter. The meter is of the rotary displacement type, capable of passing 60,000 cubic feet of gas per hour, which is required for the maximum gas demand. After passing through the meter, the gas is brought to two centrifugal gas boosters electrically driven by two 5 h.p. motors. Each one of these boosters is capable of delivering 60,000 cubic feet of gas per hour at the maximum pressure of twelve ounces, which is adequate to supply the burners in all three boilers at one time. From the boosters the gas is brought through an eight-inch welded line containing a butterfly valve, to the six-inch header in front of each boiler. From this header a three-inch line equipped with a lubricated plug cock serves each burner. An eight inch gate valve controls the flow of gas from the eight-inch line to each header. Secondary air is admitted to the burners by means of sliding doors on the front of each burner.

The oil burning equipment consists of two oil storage tanks of 5,000 gallons capacity each, an oil heater, oil strainers and oil pumps which deliver the oil to the burners. When oil is to be used as fuel, an especially designed oil burner is inserted through a circular opening in the center of the block of mixing tubes and extends into the combustion chamber. At the point where the oil is admitted to this burner, a steam line introduces steam, and the oil is atomized in this manner. Sufficient air for proper combustion is allowed to enter through the same sliding doors which are used when burning gas.

Automatic Control of Burners for Either Gas or Oil

The operation of the burners when using either gas or oil is completely automatic once they are lighted. Regulation of the flow of gas is obtained by means of a master control which actuates the butterfly valve on the gas line, opening it or closing it accordingly as the steam pressure on the boilers falls below or rises above that point for which it is set. The same master control also regulates the flow of oil to the burners by slowing down or speeding up the oil pumps as the demand for steam varies. On each boiler also is attached an automatic damper control which maintains proper draft conditions in the boilers at all times.

By way of further increasing the efficiency of operating the plant and to make available data for



This is the new installation (one boiler) showing the three gas and oil burners. To switch from one fuel to the other requires only a few minutes work. The cabinet at the left registers the draft, stack temperature, horsepower load, and the steam flow

use of the chief engineer in organizing the work of his crew, steam flow meters, CO_2 recorders, boiler water feed regulators, and stack temperature recorders have been installed in connection with the new boilers and burners. With the help of the information furnished by these devices, the engineer is able to keep a very close watch on the workings of his plant and a comprehensive record of its accomplishments.

Operating Costs

Before quoting figures on the cost of steam generated by gas, it should be noted that gas is used during the period from April 1, to October 31, inclusive, of each year, oil being used for the balance of the time. The reason for dividing the year in this manner is that the Chicago gas company, The Peoples Gas Light & Coke Company, has put into effect a particularly low rate for gas used for space heating, steam generation, and water heating during this period by hospitals, hotels, apartment buildings, and other large users. The Gas Company is able to make a low rate for gas used during this period because it does a great deal of domestic house heating business during the balance of the year, and under the terms of its contract with the Pipeline Company, from which it receives natural gas from Texas, it has available an excess supply during the warmer months, which it can afford to sell at promotional rates.

Since there were no means of measuring the amount of steam produced, prior to the installation of the above described apparatus, it is impossible to give the cost per thousand pounds under the old system. With the aid of the steam flow meters, however, it is possible to state the cost per thousand pounds of steam with gas as fuel. Based on operation of the boilers during September and October of last year, the fuel cost per thousand pounds of steam produced was $0.28. The actual total amount of steam produced during these two months was in all probability higher than was produced during the same two months of 1935, since there were more patients in the hospital in 1936 than in 1935. However, assuming the amount of steam produced both years was the same a comparison of the fuel costs for these two months of 1935 and 1936 shows a saving by the use of gas of about $950.00 per month. It is anticipated that when comprehensive figures showing the operating cost with oil become available, they will indicate an excess over the cost with coal. Taking the year as a whole, it is evident that the total combined gas and oil costs will run well under old costs with coal, in spite of an indicated increase in steam production. Therefore, the change in fuels, from a purely economic standpoint, was a wise one.

The work of modernizing the boiler room of this hospital is still incomplete. When it is finished, however, it will be possible to maintain the same precise methods of cost control now found in the other departments of the hospital.

The New Charity Hospital in New Orleans

On the site of its more than 100-year-old predecessor, New Orleans' $8,000,000 new Charity hospital is nearing reality.

The historic building that gave refuge to the sick and injured through the years have been razed, and in their place will tower a structure of steel and concrete ranging from 11 to 19 stories high, and containing at least 2,000 beds.

The impending construction of the modern house of mercy was made possible through a grant of $3,600,000 by the federal public works administration. The remaining money needed for its erection comes from bonds issued by the board of directors of the hospital, to be retired by the dedication of $400,000 annually of the corporation franchise tax.

Ceremonies signalizing the demolition of the old hospital buildings were held on the institution's grounds October 22, 1936. In his address commemorating the event, Governor Richard W. Leche said that the new hospital "will be a tribute to the physicians who have given their time and knowledge to aid the poor and afflicted, the nurses who have cared for these ailing persons and the good Sisters of Charity who have rendered noble services here."

In addition to the main building, there will be an ambulance house, a new nurses' home, a laundry building, an extension of the power plant, an incinerator, carpentry and machine shops.

Delegates or visitors to the Biennial Congress of the International Hospital Association in Paris will be interested to know that a number of other conferences are being held at about the same time. Especially important is the Second International Congress of Private Hospitals and Nursing Homes, which is to be held in Paris from July 12 to July 17, 1937. The Secretary of the Association is Dr. Bussard, 8, Avenue du 11 Novembre, at Bellevue (Seine-et-Oise), France.

Medical Social Aspects Involved in Problems of Crippled Child

MARGARET W. WAGNER, Executive Secretary
The Benjamin Rose Institute, Cleveland, Ohio

ANY plan to provide adequate medical care for the crippled child must include consideration of the social factors involved. Orthopedic care usually covers a period of months or years and its successful termination may depend upon the social factors. Parental attitudes, the home situation, finances, and local resources play important parts. A plan for the crippled child must take into account the family as a unit, since the carrying out of medical recommendations may mean that the family has to move to a different neighborhood accessible to a special school or institution, move from the third floor to the first floor, or make other changes in their mode of living. Because the limitations imposed by a physical handicap may prove less important than emotional handicaps, the attitude of the family toward the crippled child is of utmost importance.

Securing the Co-operation of the Parents

Not so many years ago one of the chief duties of the medical social worker was to overcome fears and prejudices against hospitals and win the confidence of the parents to secure medical attention for the child, but due to education much of this antipathy has been overcome. However, it is of vital importance that the parents not only consent to the treatment, but that they have a complete understanding of what is involved in order that they may assume a positive role in the rehabilitation of the child. We would probably all agree that our objective in providing care for the handicapped child would be: First—Adequate medical care in order to minimize the physical handicap through surgical intervention, the use of braces and muscle re-education through physiotherapy and occupational therapy. Second—To provide the opportunity for normal personality development through suitable home environment, proper parental attitudes, normal relationships with contemporaries and educational opportunities to the end that the child may become a useful member of society.

Importance of Social Aspects

The following instance of the rehabilitation of a crippled girl illustrates the importance of considering the social as well as the physical aspects of this situation. Miserable, forlorn, sixteen-year-old Helen was brought to a hospital for crippled children. Normal and happy in early childhood, she had shown no symptoms of disease until two years before the death of her parents, which had left her alone. An aunt had taken her only from a sense of duty. The money she inherited was used by the aunt for medical care in a sincere effort to overcome Helen's disability, but with little success. Helen was the victim of a rather rare condition which manifested itself in necrosis of the bones of the lower extremities. Repeated fractures had resulted in increasing deformity as the unions were never successful. When we first saw Helen she could not walk. When not in a wheelchair she propelled herself on the floor with her hands. Her arms and hands, apparently not involved, were strongly developed.

Helen finished high school in her small home town and her aunt was no longer physically nor financially able to keep her. She arranged to have her sent to the city, hoping that she might learn to be self supporting there. At the outset it became apparent that Helen was intelligent, ambitious, and courageous, also that she was unhappy and discouraged. The transition from a private home in a small town to being the oldest girl in a children's institution was a difficult adjustment to make. She showed no aptitude for sewing, the first attempt in vocational placement. The social worker recognized this and a change was made to switchboard operating, which wrought miracles.

With pleasure in her work, encouraged through successful accomplishment, Helen's greater potentialities became more apparent. The social worker then moved Helen from the institution to a foster home, where she lived in a normal environment and had the interest and attention of a kindly foster mother. Her straggly flaxen hair, now brushed to shining smoothness, was evidence of a growing self respect, and as the lines of discouragement and unhappiness were displaced, her face took on unexpected charm.

It took but a few months to realize that Helen could go as far as opportunity and her physical

A sewing room in the Training School of the Association for Crippled and Disabled, Cleveland

condition would allow, and at this point an orthopedic consultation was asked. A medical and social diagnosis revealed the problem; the objectives were outlined and a plan proposed—a radical operation involving both extremities with the possible amputation of the lower left leg would enable Helen to walk. It would necessitate hospitalization and convalescent care, the purchase of a brace and an artificial limb. The objective was a part time job and an opportunity to attend business school. The patient shared in the planning and understood the objectives. She accepted the plan.

How Helen Progressed as the Plan Developed

A year later Helen was walking with the aid of two crutches. Her success in school added to her assurance. The plan was working. By the time her physical and vocational training were completed Helen could walk with one crutch and she secured her first real job. The surgeon, the physiotherapist, the rehabilitation officer, the social worker, and the patient had all played a part in the program. The well rounded plan did not allow the patient to be dropped at any crucial point to flounder and relapse into old discouraging mental patterns. All her potential strengths—physical, mental, and emotional—were recognized and built upon.

A foundation was laid that carried Helen far. Four years later she was driving her own car, bought with her savings. She had demonstrated more than usual ability and continued at night school until she became a full-fledged accountant. When last seen Helen, using only a cane, was studying law and preparing herself to be a certified public accountant, a job in which she assured me her physical handicap need be no detriment.

It is not conceivable that even with Helen's unusual intelligence, tenacity, and courage a plan could have met with equal success if it had not taken all factors into consideration. The drab, discouraged girl who entered the institution would not have been a good candidate for such a radical operative procedure, and to have released Helen's innate abilities would have been impossible without some improvement in her physical condition.

Medical and Social Planning for the Patient

The medical and social planning is so interrelated, so interdependent that it is not possible to treat one without the other. The plan for medical care affects the patient's way of life and his family group, and in turn parental attitudes, the patient's own attitude, environmental factors, and the financial status of the family play impor-

tant roles in the physical rehabilitation of the child. The medical social worker in the hospital has the responsibility for treating the social situation in order that the medical treatment will be most effective. She is responsible for making it possible to carry out the doctor's recommendations. More superficial but important is her role in arranging for placement on discharge. She may utilize community resources, such as a convalescent hospital, a specialized institution, a foster home care, or secure the family's cooperation in making changes which would enable the patient to return home. She is responsible for seeing that the doctor's orders for physiotherapy, occupational therapy, or other recommendations are continued and that the patient returns for observation. The difficulty in meeting these problems is largely dependent on resources within the community. At times it may try the ingenuity and resourcefulness of the worker, but at best it is the mechanical part of the job. The real challenge which has so much social significance lies in the treatment of the social and emotional factors surrounding the patient in order that his character may develop and keep pace with the progress being made in his physical development. Just as the parents need help and instruction concerning the child's physical handicap, they need help in interpreting their own attitude and behaviour toward the child.

How often we hear a mother or father say, in referring to their crippled child, "Why did this have to happen to me?" The distressing deformity is looked upon as a "visitation" upon the parents. It may be considered by the mother to be a punishment and thus becomes associated with some act which her conscience has censored. She develops a feeling of guilt or even resentment in relation to the child, and to compensate finds comfort in martyrdom—a martyr to her child. To determine these deep underlying causes and to treat them is to release the child from emotional bonds—more handicapping than his physical deformities. This solicitude of the parents, resulting in over-protection, may be reflected in the child through anti-social attitudes, a sense of inferiority, which is expressed in an effort to dominate the situation in the home through using his handicap as his weapon—a dangerous beginning. The presence of a crippled child in the home may even have a serious effect upon the other normal children. It may be that the cost of medical care deprives them of necessities, or it may mean that the mother gives so large a share of her time and devotion to the disabled child that she neglects to give either the proper physical attention or love to the other children. Thus in early childhood a pattern is established which will prevent later adjustment to the outer world, unless corrected.

The other day while passing through a children's ward I saw a lovely child of four years. Her hair fell in ringlets around her pretty face. Her eyes shone with humor and intelligence as we joined her in her make believe game. She was a normal, happy child except for hands and arms, both congenitally deformed. The bones were shortened and bent, and there were no elbow joints nor wrists. There were three fingers on one hand and two on the other. They had the appearance of claws. A corrective operation had changed the position of the arms, giving them maximum freedom of movement. She used her hands deftly and in handicraft she was exceptionally clever and could do anything. This child as an individual set apart has a slight handicap. She has already adjusted to that, knowing nothing else. Her real handicap will be in meeting a world of people different from herself, and it will be their attitude toward her that will handicap her. It will be the wise mother who can prepare her for this and not share in it herself. May not the sight of this deformed child arouse within her a feeling of failure and inadequacy in having produced her? May she not have a sense of shame? If this is true, can she meet the problem intelligently and unemotionally without help?

The Therapeutics Companionship and Understanding for the Crippled Child

All of you who are familiar with a children's ward in a hospital have had experience with the child who on admission is unhappy and unable to get along with the other children. This may be his first experience in the outer world away from the protection of his parents. We know that usually the opportunity to meet companions on an equal basis will bring about a change within the child and that the children themselves are his best teachers. Usually before he has left the hospital he is reaching out for companionship and friendship, so necessary for character and development. This progress may be considered as constructive as the result of a corrective operation, and just as you protect the benefits gained physically by braces, physiotherapy, etc., so should the benefits in character development be equally safeguarded and opportunity made for continual improvement.

Social Adjustments for the Handicapped Child

The first or earliest adjustment is usually made

most successfully with other handicapped children. The child whose progress will be retarded in a regular school, where competition is unequal, will make rapid strides in self-confidence in a class with other crippled children. Three boys who were transferred from a children's ward to a special ward for cardiacs, where all the activity was strictly limited, began to show a marked improvement in their condition. Upon being told, one remarked, "Sure, here we can lie down and keep quiet without being called a baby." Even in the hospital ward the social factors, that is, the boy's normal desire to hold his own with the other boys, proved to be a factor in treatment.

That which we see is apparently much more emotionally disturbing than that which we know to be true. Thus the deformity of the crippled child arouses sympathy, concern, and protective instincts far in excess justified by the disability. The child suffering from a cardiac involvement may be more seriously handicapped, but usually his parents must constantly be warned against over activity and impressed with the seriousness of his ailment. Just the opposite is too often true with the crippled child. Thus early in his career he finds himself judged in the light of what he has lost rather than what he has. Medical treatment attempts to reduce the physical handicap, enabling the patient to build on his assets as Helen was able to do. Social treatment must recognize these constructive positive factors if the objective is to be obtained in the care of the crippled child. Too often in a description of Johnny we hear "his left leg is paralyzed and he has little use of his left arm or left hand." Instead, speaking socially, let us say "Johnny has an I. Q. of 120, is friendly and likable and spends his spare time making aeroplanes and wants to be a mechanic."

There is no child who suffers more through emotional blocking on the part of his associates than the spastic child. Exaggerated, grotesque movements, disturbing facial mannerisms efface the character and abilities of the child until familiarity lessens our attention to his erratic movements and enables us to appreciate and evaluate his assets. As the adult spastic knows, his greatest handicap is the stranger's reaction to his involuntary muscular spasms. So until medical science can discover a more effective treatment of the physical handicap, the therapy utilized is directed to his social adjustment in an effort to make him less of a burden to himself and others. The purpose of muscle re-education and control through physical and occupational therapy is to enable the child to tie his own shoe laces or cooperate in play with other children. Parental

A student receiving her office training at the Association for Crippled and Disabled, Cleveland

instruction gives the child an opportunity to develop as a human being in his own home.

Where the Responsibility for Treating the Social Aspects Lies

Who is responsible for treating the social aspects of the problem? In urban areas it is the medical social worker in the hospital or specialized agency, whose training particularly prepares her for this difficult job. In rural areas, just as the country doctor must be a specialist in many fields, so frequently the public health nurse must play the role. It may even fall to the doctor to concern himself with the social treatment of his patient. The Social Security Act may make it possible to reach back to these isolated areas and give these children not only the benefits of proper medical care but social treatment as well, to the end that their handicap may be minimized to the greatest possible degree. Too frequently these children have been brought from their homes to a hospital and given the best medical care obtainable. The results were gratifying to the orthopedic surgeon, but the social situation remained untreated and unrecognized. The diagnosis and treatment of personality difficulties, family relationships, and social implications in the patient's situation by the medical social worker in the hospital and the realization that medical and social treatment should run parallel courses in the care of the crippled child marks the next milestone in the dramatic progress that has been made in the past decade.

EDITORIAL COUNCIL

BERT W. CALDWELL, M.D.,

Editor

G. HARVEY AGNEW, M.D.,

Secy., Department of Hospital Service,
Canadian Medical Association,
Toronto, Ont., Canada.

W. L. BABCOCK, M.D.,

Director, Grace Hospital,
Detroit, Michigan.

ASA S. BACON,

Superintendent, Presbyterian Hospital,
Chicago, Illinois.

CAROLYN E. DAVIS,

Seattle, Washington

NATHANIEL W. FAXON, M.D.,

Director, Massachusetts General Hospital,
Boston, Massachusetts

S. R. D. HEWITT, M.B.,

Superintendent, St. John General Hospital,
St. John, N. B., Canada.

ROBERT JOLLY,

Superintendent, Memorial Hospital,
Houston, Texas.

WALTER E. LIST, M.D.,

Superintendent, Jewish Hospital,
Cincinnati, Ohio.

MALCOLM T. MacEACHERN, M.D.

Associate Director,
American College of Surgeons,
Chicago, Illinois.

CHRISTOPHER G. PARNALL, M.D.,

Medical Director, Rochester General Hospital,
Rochester, New York

WINFORD H. SMITH, M.D.,

Director, Johns Hopkins Hospital,
Baltimore, Maryland.

WILLIAM H. WALSH, M.D.,

Hospital Consultant,
Chicago, Illinois.

FREDERIC A. WASHBURN, M.D.,

Superintendent, Cambridge Hospital,
Cambridge, Massachusetts

EDITORIALS

Registered Nurse or Nurse's Aid—Which?

In almost every section of the country it is apparent there is a definite shortage of nurses. Not only do our hospitals experience great difficulty in securing competent nurses, but it is almost as difficult to secure nurses for the patients in their homes. Whatever the cause may be, whether insufficient salaries, long hours, or what not, hospitals cannot secure the required number of registered nurses that the service demands.

As a result, our institutions are using nurses' aids, practical nurses, or ward maids, who under the supervision of the floor supervisor, are performing a large part of the nursing service in many of our institutions. It will not be many years before these young women, through direction, observation, and the instruction which they receive at the bedside, will be able to perform intelligently and satisfactorily a larger nursing service than at present. Indeed there is a movement to outline courses of study, and methods of instruction for them which when completed, will not widely separate them as practical nurses, from the graduate and registered nurse. They will in the end bear about the same relation to the registered nurse, as the graduate of a junior college bears to the graduate of a college of liberal arts.

Hospitals in selecting nurses' aids, are employing bright, alert, and willing young women, who are eager to learn and serve. They fall largely in that class of young women, who do not quite measure up to the necessary scholastic attainments required for admission to the training school, but who are intelligent and want to learn. The longer they remain at the work, the more worth while their services. Gradually they are taking the places which would under other circumstances be filled by registered nurses. In one of the best known institutions in this country, seventy-five per cent of the nursing service is performed by nurses' aids or practical nurses, and both the medical staff and the patients are satisfied.

Shall this program continue? Certainly it is not the one of selection so far as our hospitals are concerned. Undoubtedly, if generally introduced it will result in one of two things, neither of which is highly desirable. Either hospitals will open up their training schools, on a standard lower than it should be, or they will maintain an inferior nursing service, through the use of untrained women, working in the hospital wards under the direction of registered nurses.

It is a foregone conclusion that there is a definite hazard for the future employment of the graduate nurse. Numerically the practical nurses almost equal the registered nurses. At present their competition with the graduate nurse is confined to bedside nursing care. With a longer period of training and instruction in hospitals, and with their numbers increasing under such a program more rapidly than the graduate nurse body increases, it will not be long until the practical nurse or nurse's aid will enter all the competitive fields of employment in which registered nurses now engage.

Meanwhile what course will the hospitals follow? They do not want to train practical nurses, or nurses' aids, and they cannot permit a default in their nursing service to the patient. If they could depend upon the graduates of their own schools of nursing to enter the employment of the hospital there would be no excuse for training nurses' aids or maintaining an indifferent nursing service. But less than one out of every six graduate nurses engages in institutional nursing.

As long as the present shortage of nurses continues, our hospitals will have to supplement their graduate nursing service with an increasing number of poorly prepared nurses' aids or practical nurses, give them such instruction and training as may be practicable, and build up and maintain the best nursing service possible under these conditions.

* * *

The Low Cost of Hospital Giving

Government, both state and federal, encourages gifts to hospitals and other charitable institutions by authorizing the deduction of the amount of the present gift for income tax pur-

poses, providing that the amount of the gift does not exceed fifteen per cent of the taxpayer's net income.

It is to be noted that present gifts save the donor, and benefit the hospital, more than future gifts, i.e., a gift that is made available on death of the donor or after the expiration of a stated period of years.

The donor may create a trust for the hospital he favors, which trust would be irrevocable, absolute, and indefeasible, and he may retain the income of the trust fund for life, and may deduct the amount of the gift from his gross income for the year in which the gift is executed. If the trust fund was $25,000, and the income on it was to go to the donor during his life and at his death the trust was to go to the hospital the present value of the trust, subject to the fifteen per cent limitations, would be deductible from the gross income of the donor. Under existing favorable rulings as to methods of computation of deductible income the donor at the age of fifty years could give his hospital $25,000 at the net cost of approximately $12,000. Many philanthropists are influenced in making present gifts to hospitals by the low net cost of their giving.

Hospitals would do well to present a study of these costs to their friends and potential benefactors. Where the donor is very wealthy and his income is proportionately large, the present gifts he makes will cost him less than half of the amount given. In addition the hospital will enjoy the income from the present gift, which will add a considerable sum each year to their endowment income.

The Robinson-Patman Act and Hospitals

The Robinson-Patman Act has for its purpose the prevention of unfair trade practices, particularly the unjustified discrimination in price between purchasers of like commodities by manufacturers or dealers. Under its provisions the vendee is penalized to the same extent as the vendor. There are no exemptions under the Act and hospitals are in the same position as other purchasers under its provisions.

The enforcement of the act is placed under the authority of the Federal Trade Commission which is not a regulatory body. It makes no regulations in the application of the law but administers the provisions of the Act as Congress prescribes. Its interest is to eliminate granting of discriminatory preferential prices to purchasers, having the authority to fix and establish quantity limits for price differentials. Cooperative purchasing is approved under the Act.

Hospitals have always conducted their purchases on an ethical basis. In purchasing supplies they have taken advantage of the customary trade discounts, and have used both the competitive bidding and the open market methods of purchasing. The necessity for careful scrutiny of prices quoted, and quality of the commodity, is just as compelling in the field of hospital purchasing as in any other business.

Hospitals are now confronted with the attitude of a number of dealers and manufacturers who are making their prices more unfavorable to hospitals than the prices previously quoted. Quantity discounts are being largely eliminated thereby placing hospitals in the same bracket as the small consumer. These vendors, giving the Robinson-Patman Act as their justification, whether in good faith or otherwise, are establishing their price quotations to hospitals on a somewhat higher level than previous to the enactment of this law.

The American Hospital Association is interested in securing the passage of an amendment to this Act, which will exempt our hospitals from its provisions. Such an enactment will soon be introduced in Congress. Members of the Committee of the House have advised that the Act was never intended to operate to the disadvantage of our institutions, and have indicated their support of the proposed amendment. Hospital purchasing departments are justified in resisting an increase in the cost of commodities when the vendor gives the provisions of the Act as his reason for such increase.

Woman's Hospitals

The first Woman's Hospital on this continent was established eighty-four years ago. Since 1853 Woman's Hospitals, devoted exclusively to the care of women and children, staffed for the major part by women physicians, and rendering a high type of professional service, have been built in all of our metropolitan centers.

The story of Woman's Hospitals is the story of one of America's greatest women, Elizabeth Blackwell. With the traditions of centuries to

support its policy, the medical profession had successfully barred women from medical colleges, and the opportunities for instruction in the art of healing. But in 1847 Miss Blackwell emancipated her sex from both social and professional prejudices and was admitted to Geneva College and began her medical studies. Not only medical men but members of her own sex, including Florence Nightingale, approved the entrance of women into the medical profession.

Miss Blackwell completed her course and was graduated with high honors. She went to London and Paris to continue her medical studies but the hospitals would not admit her unless she dressed like a man. She insisted on wearing the clothes proper to her sex, and she finally had her way and was admitted to, and studied in the leading hospitals of London and Paris.

She established her practice in New York and prospered. She was a good speaker and a facile writer. She won many friends to the cause of professional education for women, and in 1853 she opened the New York Infirmary for Women and Children. In later years she added a Medical College for Women to the Woman's Hospital. In 1869 she went to London and became a professor in the London College of Medicine for Women. She died in England in 1910.

Woman's Hospitals, as a rule, are modern in construction, well equipped, and well operated. They afford the same opportunities for the training of women residents and interns, that other hospitals offer to male graduates in medicine. The nursing schools are good schools, and they perform a very useful educational service for women wherever they are located. Their increasing numbers and the fine work they are doing is a tribute to the modest, retiring but determined little lady from New York who opened the doors of the medical profession for her sex, and who became one of its greatest teachers—Elizabeth Blackwell.

* * *

Changing Conditions

The economic condition which confronts the world today, together with the problem of social security, is having its effect upon our hospitals. In the face of increased payrolls, higher prices, and additional taxes, how long will the major portion of our hospitals be able to continue to give hospital care for their personnel gratis or at heavily discounted rates?

A plan is gaining favor of offering an opportunity to employed personnel, and in some instances of making it compulsory for them to contribute a small amount monthly to a fund which helps defray the cost of their hospitalized illness. A certain group of medium sized hospitals have charged its employees twenty-five cents a week over a period of several years. This money is placed in a fund so that when any employee is ill, he is given a private room at the regular prevailing rate of five or six dollars per day, and the hospital bill is paid from the fund. While it may not meet the actual amount charged every year, some years there has been a small surplus, so that over a period of years, it breaks about even. In a larger hospital, for a period of two years they have charged their employed personnel seventy-five cents a month to create a similar fund. This is also offered to their staff members. They give private room service, but for a limited time; eighteen days for the first year; twenty-two days the second year; twenty-six days the third year. Again charges are made at the prevailing rate, which is slightly higher than in the first group of hospitals. The money collected has not quite met the amount charged against the fund, but the second year deficit was approximately only one-third of the first year deficit.

The hospitals are well pleased with the results of their plan. That group of employees, unfortunate enough to be ill, has been relieved of the anxiety of having either to accept charity or perhaps pay a large hospital bill. Many an institution has had the experience of having a heretofore valuable worker become a disgruntled one, when receiving a bill for hospital service, and in the end it costs the hospital far more than it received for the service rendered.

Trustees often feel that if their employees receive fair compensation for service, the hospital should have no greater responsibility for their physical welfare, than have other types of business. Will their attitude change, particularly in communities where a trustee or his friends have employees who are covered by some type of group hospitalization plan?

Business men, as well as the people in the lower income brackets are learning that many employed people can meet the cost of illness when it is regularly budgeted. In the light of changing economic conditions, does it not evolve upon hospital trustees, where group hospitalization plans are available, to see that the benefits are offered to their employees, if they are going to be billed for hospital services? In those communities where a group hospitalization plan is not available, does it not become mandatory upon the trustees to devise some plan for the benefit of their employees?

Planning the Hospital Dietary Department

PERRY W. SWERN, Hospitalization Engineer
Chicago

THE food service in a hospital is a vital factor in the establishment of public opinion, for or against the hospital. The entire personnel, doctors, and trustees should be constantly interested in it. Basically hospitals are established to nurse the sick back to health, and we take for granted that the nursing is good and that the surgery, radiology, pathology, and the other services are in the hands of experts. To disturb this faith some glaring break in technique must happen.

However the dietary department is evaluated quite differently from the other departments. The patients usually know what they want to eat and how they like it cooked, and are quick to conclude that the food is excellent, just ordinary, or bad. The patient's opinion of the other services, for instance the nursing, is only relative—hospital people can quickly measure these services but the patients must rely on what others say, having not seen enough hospital service to know. But not so with the food, they are sure they know good food, and will not hesitate to voice their opinions, which will spread very quickly through a community. Every woman patient is potentially a good cook herself, and the men remember the dishes mother used to make. Eavesdrop on several conversations between patients, their visitors, or doctors, and you will find the hospital food is often the subject of discussion. It is a subject that all can talk about without becoming personal—why not make this talk boost the hospital?

Visualize the Department Service While the Building Is Still on Paper

For the purpose of this discussion it is assumed that first class wholesome and dependable supplies are purchased and that the planning of the menus and set-up is in the hands of a trained dietitian or one with a thorough understanding of food problems. If not, then no matter what the physical arrangement may be the results will be disappointing, the difference being that the service will be considerably worse if the physical layout is ill conceived. We frequently marvel at the results that are sometimes obtained in absurd and poor conditions. The answer is that there is a real dietitian on the job and she is making things work in spite of the surroundings. Few know the effort, thought, ingeniousness, and time required to make a smooth food service under poor conditions. These super-dietitians are hard to find and will only put up with such conditions for a short time. It is better to make the physical arrangement so things can run smoothly and without constant conflict among the hospital personnel. It costs no more—just some careful thinking through about the food service when the building is still on paper.

In our thought the food service begins when the delivery trucks come onto the site and does not end until all the patients have eaten and gone to sleep, and the garbage is off the property. Failure to visualize the service from such a beginning through to the finish may create inconvenient arrangements in a few spots that will completely upset an otherwise commendable service. It has always seemed strange why the milkman must deliver in the dark and why the garbage man fails to come on the hottest days, but they do and you must make arrangements to control the problems set up these conditions.

In thinking of the food service from a production manager's viewpoint, you will produce close to 200,000 units per year in a 100 bed hospital, and there will be a great variety of models, individual finishes, and specials. If any of the movements that make up the unit cost are wasteful of either supplies or labor, the total food bill will cut a bigger slice out of the expense dollar. When you realize that twenty-five per cent to thirty per cent of the dollars that pass through the hospital's bank account can be charged to the dietary department, you will stop, look, and listen before you make off hand decisions about the food service and will not wait until your construction gets to the brick and mortar stage. Just one penny off the cost per unit means $2000.00 a year less on the budget of a 100 bed hospital.

With the above as a sketchy background, please pardon the rushing into suggestions. The circulation of the food is really the skeleton of the plan. Nothing happens more frequently and nothing requires more precision and dispatch than the serving of food—the "show must go on" regardless of any emergencies or extenuating circumstances. The patients expect results, and excuses will not satisfy that gnawing feeling.

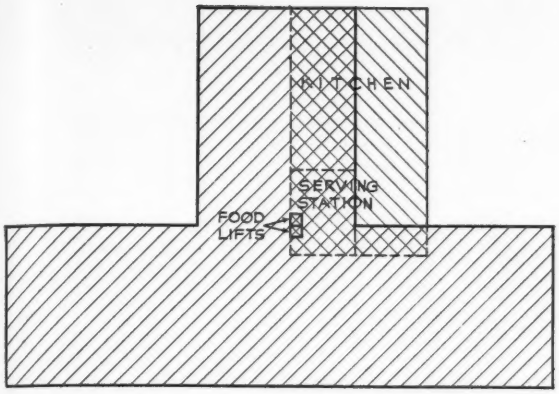


Figure 1—Hospital Kitchen and Serving Station Locations in "T" Type Plan.

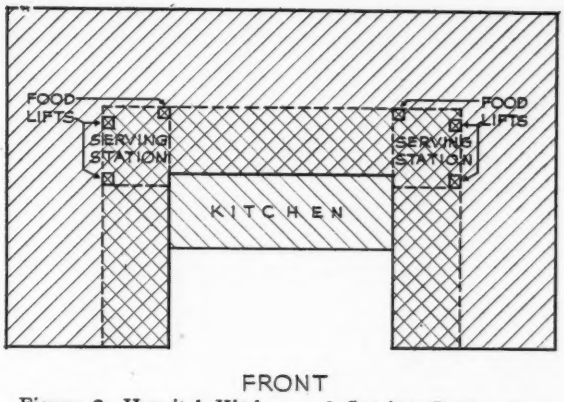


Figure 2—Hospital Kitchen and Serving Station Locations in "U" Type Plan.

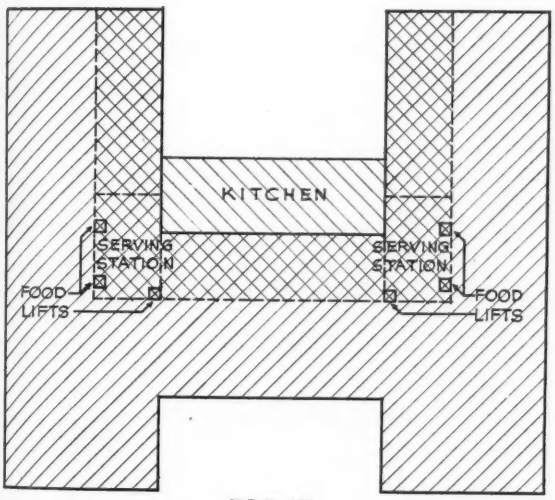


Figure 3—Hospital Kitchen and Serving Station Locations in "H" Type Plan.

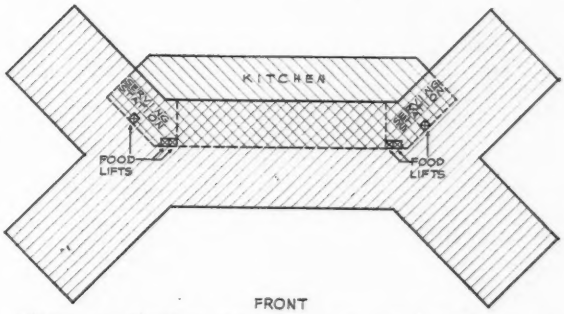


Figure 4—Hospital Kitchen and Serving Station Locations in Double "Y" Type Plan.

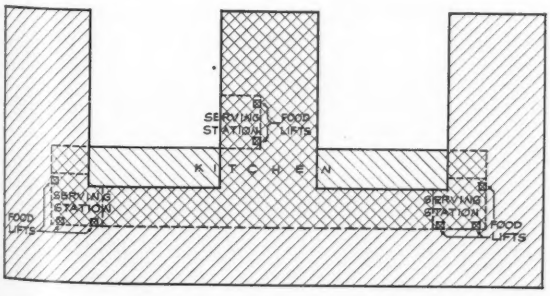


Figure 5—Hospital Kitchen and Serving Station Locations in "E" Type Plan.

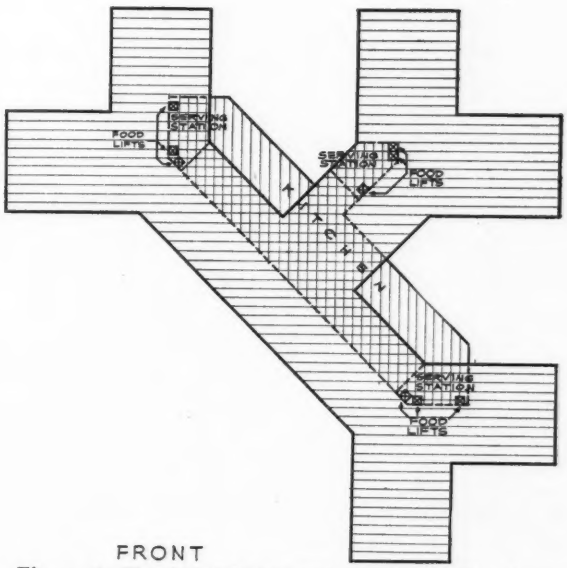


Figure 6—Hospital Kitchen and Serving Station Locations in Triple "Y" Type Plan.

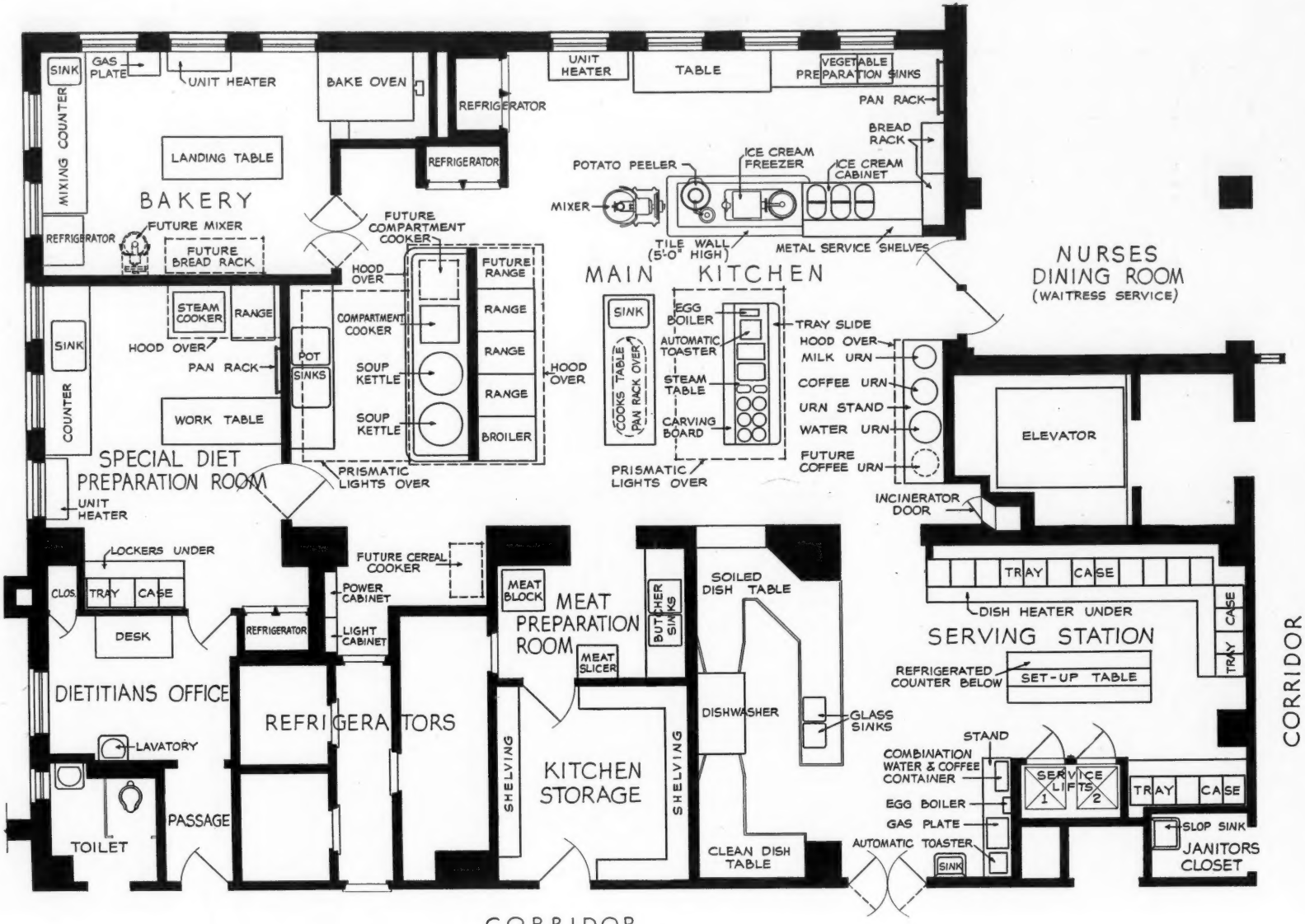

SINK
GAS PLATE
UNIT HEATER
BAKE OVEN
REFRIGERATOR
UNIT HEATER
TABLE
VEGETABLE PREPARATION SINKS
PAN RACK
MIXING COUNTER
LANDING TABLE
BREAD RACK
POTATO PEELER
ICE CREAM FREEZER
ICE CREAM CABINET
REFRIGERATOR
BAKERY
MIXER
FUTURE MIXER
FUTURE COMPARTMENT COOKER
REFRIGERATOR
FUTURE BREAD RACK
TILE WALL (5'-0" HIGH)
METAL SERVICE SHELVES
NURSES DINING ROOM (WAITRESS SERVICE)
HOOD OVER
FUTURE RANGE
MAIN KITCHEN
STEAM COOKER
RANGE
COMPARTMENT COOKER
RANGE
SINK
EGG BOILER
TRAY SLIDE
HOOD OVER
SINK
POT SINKS
SOUP KETTLE
RANGE
AUTOMATIC TOASTER
MILK URN
HOOD OVER
PAN RACK
COUNTER
COOKS TABLE
PAN RACK OVER
STEAM TABLE
COFFEE URN
WORK TABLE
SOUP KETTLE
RANGE
CARVING BOARD
URN STAND
ELEVATOR
SPECIAL DIET PREPARATION ROOM
BROILER
WATER URN
PRISMATIC LIGHTS OVER
PRISMATIC LIGHTS OVER
FUTURE COFFEE URN
UNIT HEATER
INCINERATOR DOOR
LOCKERS UNDER
FUTURE CEREAL COOKER
TRAY
CASE
CLOS.
TRAY
CASE
POWER CABINET
MEAT BLOCK
MEAT PREPARATION ROOM
BUTCHER SINKS
SOILED DISH TABLE
DISH HEATER UNDER
SERVING STATION
DESK
REFRIGERATOR
LIGHT CABINET
MEAT SLICER
TRAY
CASE
REFRIGERATED COUNTER BELOW
SET-UP TABLE
DIETITIANS OFFICE
REFRIGERATORS
DISHWASHER
GLASS SINKS
STAND
LAVATORY
SHELVING
KITCHEN STORAGE
SHELVING
COMBINATION WATER & COFFEE CONTAINER
SERVICE LIFTS
1
2
TRAY
CASE
EGG BOILER
GAS PLATE
SLOP SINK
TOILET
PASSAGE
CLEAN DISH TABLE
AUTOMATIC TOASTER
SINK
JANITORS CLOSET
CORRIDOR
CORRIDOR

Figure 8

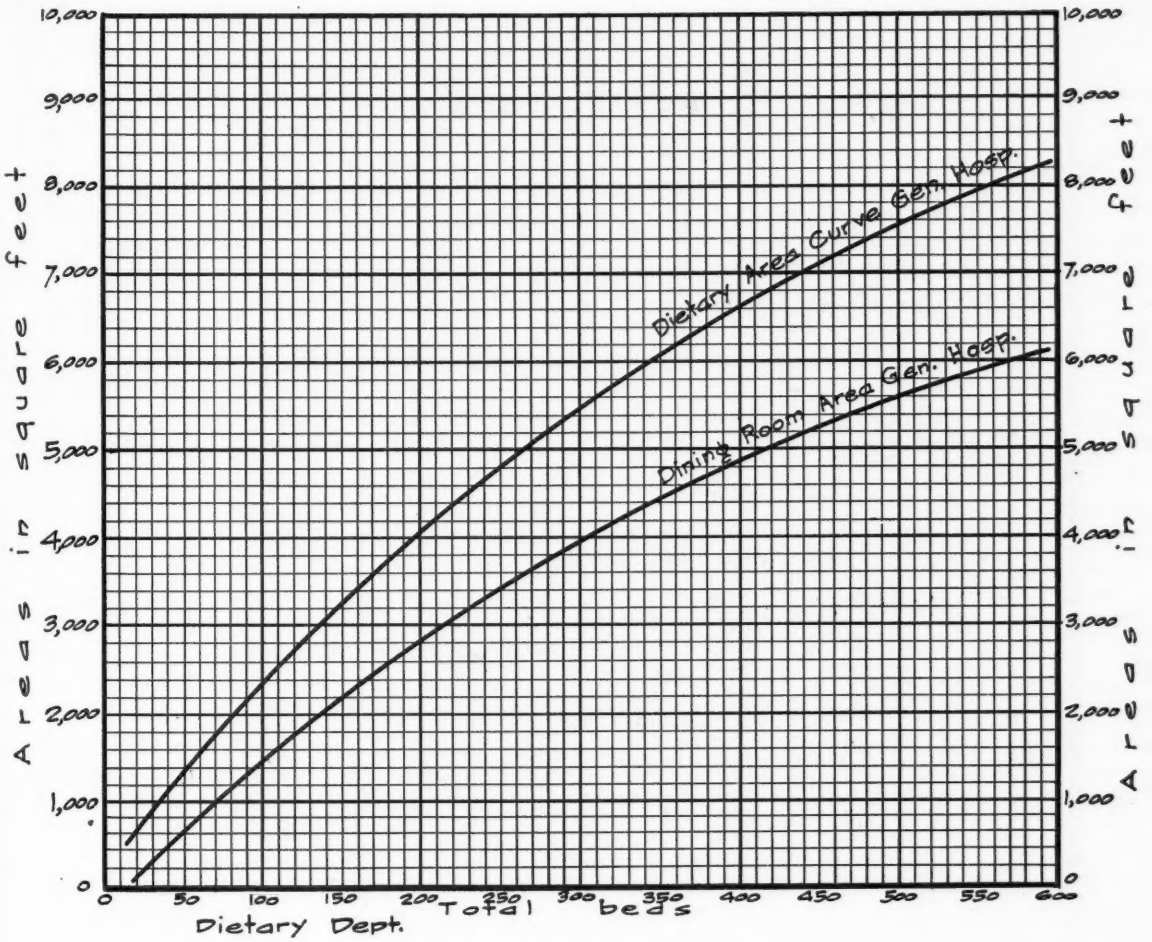


Figure 7

The total area in the Dietary Dept. consists of the sum of the floor areas of kitchens, bakery, preparation rooms, special diet rooms, serving rooms, diet kitchens, dietitians' offices, kitchen store rooms and refrigerators, and any other areas devoted entirely to food storage, preparation and serving for patients, nurses, help and guests. Actual dining room areas set up separately with adjoining serving rooms included in the dining room areas and not with the kitchen areas

You must select the type of food distribution early. Shall it be central tray service; floor diet kitchen service; or one of the many combinations that are possible between these two? Offhand it might seem wise to build so that any system or all of them could be tried out. If you were dealing with more changeable materials and not such expensive equipment it might be possible. We have found that the efficiency can be stepped up greatly if the decision is made in the plan stage and then the construction carried forward on one basis. The merits of the various systems and where each best serves is hardly subject matter for this article but we do need to allocate them a bit. If you have a voluntary hospital catering to all classes of patients in an average community, you need extreme flexibility, complete supervision, and low costs; central tray service seems to produce the best results. If you have a public supported institution in which the majority of the patients come from one strata of the community, then the ward or floor diet kitchens can be used satisfactorily and economically. Some of the more deluxe hospitals that service principally the people of wealth in a community are best handled with a combination of the two types of service. Where extreme flexibility and ability to cater to all patients' whims is required, the cost of construction and cost of service will be considerably higher.

Almost immedately after the type of service is selected the planning "yardsticks" begin to vary, there are very few rules or ideas that are fundamental to them all. Briefly, handle the supplies as little as possible; see that the travel from the receiving of the supplies, storing them, and through the processing and serving is accomplished without any back travel. Avoid crossing other circulations in the hospital and eliminate

Figure 9

"bottle necks" in the travel. Arrange the layout so that if the normal travel is blocked, the food can still come through to the patients. Insist on separate vertical transportation for the food to the floors, regardless of the system, and see that the controls are such that no department or thoughtless individual can upset the distribution. In the diet kitchen type of plan some of these items are not so important because the food must go up considerably in advance of the zero hour of meal time. The equipment in the diet kitchens must be such that every demand can be taken care of "on location" without running back to the main kitchen.

Location of the Kitchen

The location of the kitchen depends upon the type of the plan and the method of serving selected. Central tray service has come to infer that the kitchen must be located in the center of the building; this is not always necessary and need not rule out central tray service if the kitchen cannot be so located. Generally—determine the location of the center of the patient population and then place your kitchen as nearly under it as possible; this reduces the horizontal travel of the food to a minimum. Remember that vertical transportation of food is cheaper and faster than hori-

zontal travel. We will not discuss top floor kitchens, there seems to be no logical reason for them, now that adequate ventilation and noise controls are available.

Figures 1 to 6 diagram the basic types of plans and indicate kitchen locations. They also indicate the location of serving stations and the vertical transportation to the floors if central tray service is to be used. Unfortunately every hospital presents a different problem and to set up rules or procedures applicable to all would be dangerous to say the least. Likewise the transplanting of a successful food service in one hospital to another that may appear to be the same can cause very "unhappy landings."

Floor Area Has Definite Relationship to Bed Capacity

The amount of floor area required for the dietary department seems to have a very definite relationship to the bed capacity regardless of the type of food service in use. Figure 7 gives two curves from which approximate probable areas required for the dietary department and the dining rooms can be obtained. These curves are the results of plotting data taken from many hospitals. It would be interesting to us if each reader would check their institution against the curves and let us hear the results. Are your areas more or less? In measuring be sure to get all the items included regardless of where they may be in your particular institution.

The arrangement of any particular kitchen, and what equipment shall be used is so definitely a problem of the individual project that detailed standards are next to impossible.

Figures 8 to 12 illustrate several kitchen layouts and should serve for checking against any new or altered kitchens. Figure 8 serves a 125 bed hospital of the Figure 1 type of plan. Figure 9 serves a 100 bed hospital of the "Y" type plan (similar to Figure 1). Figure 10 serves 150 beds of the Figure 2 type plan (reversed). Figure 11 serves 300 beds of the double "Y" type plan (Figure 4). Figure 12 serves 500 beds "E" type plan (Figure 5).

Arrange Food Focal Points With Vertical Transportation in Mind

In attacking a layout we suggest, first, that you visualize the handling of the food in the nursing units. Establish a focal point in each of these units, as near as possible to the center of the group of patients to be served. Then visualize the units collectively, with the idea of arranging these food focal points so that vertical transportation can bring the food to them. In other words the vertical transportation becomes a tree and the distribution on each floor becomes the branches. If the branches are nearly all the same length the horizontal travel is at a minimum. The number of "trees" required is established by the bed capacity of the institution. Roughly 100 to 125 beds seems to be the strategic figure to use. At the base of each of these "trees" is a serving station, which like the tree's roots furnishes all the food for the patients directly over them. Endeavor to place these "trees" so that their serving stations will be grouped around your main kitchen. From all of this, the general skeleton of the plan will take form. There are many other factors determining plan layouts and it requires skillful imagination to adjust them all so that the food travel is not distorted to a point where it hurts the service.

The food focal points in the nursing units may just be alcoves off of the corridors with tray racks in them, or they may be full fledged diet kitchens, depending upon the system of service to be used. The "food lifts" (note that we do not call them dumb waiters) are small push button controlled elevators arranged to open directly into the serving stations and focal points on the floors. Each "tree" should have not less than two lifts (arranged in battery), if the building is high, or the total of patients served is over 100 more than two lifts will be required. The cabs on the lifts should be designed to carry only four trays at a time for central tray service, and made only slightly larger if the diet kitchens are used. Frequent, rapid trips will handle the food better and will cut down the standing time required to load and unload the lifts. The lifts may be designed large enough to take tray carts, loaded in the serving stations, with eight or more trays to be taken to the floors. However our experience indicates that the slight advantage gained in not having to carry the trays on the floors is offset by the loss of time—spilling of liquids—and the cleaning and parking of the carts. In other words, when the trays are to move horizontally, carry them, and only use mechanical means for the vertical transportation.

Central Tray Service

In central tray service the serving stations are fully equipped and arranged to perform all of the assembly and short order work on the regular trays. The food is brought to these stations, before the zero hour of meal time and placed in steam heated equipment or under refrigeration. The butters, milks, creams, etc., are made ready and placed conveniently, so that after the service starts the work in the serving station consists of

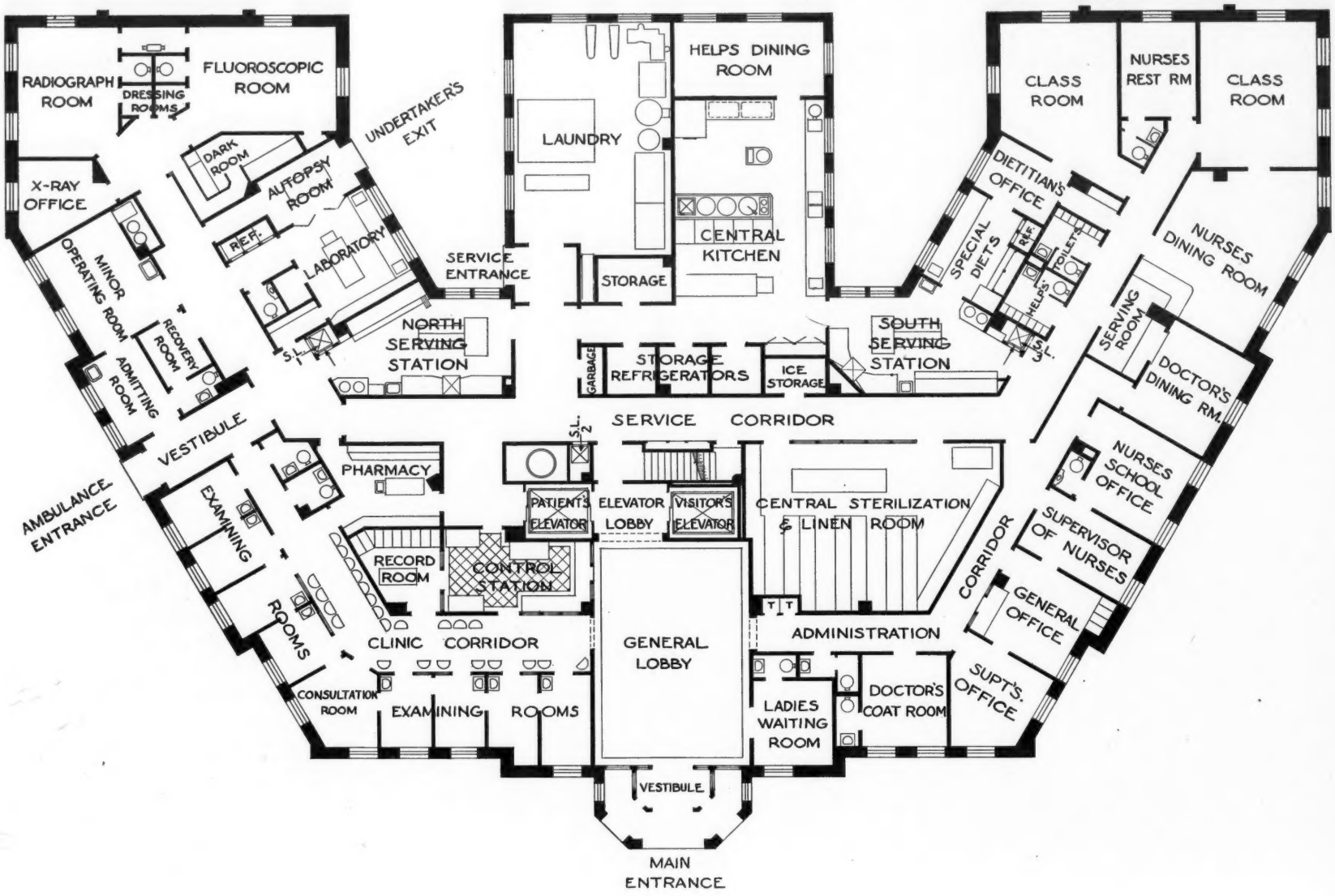

RADIOGRAPH ROOM
DRESSING ROOMS
FLUOROSCOPIC ROOM
UNDERTAKER'S EXIT
X-RAY OFFICE
DARK ROOM
AUTOPSY ROOM
REFF.
LABORATORY
MINOR OPERATING ROOM
RECOVERY ROOM
ADMITTING ROOM
VESTIBULE
AMBULANCE ENTRANCE
EXAMINING ROOMS
CONSULTATION ROOM
PHARMACY
RECORD ROOM
CONTROL STATION
CLINIC CORRIDOR
EXAMINING ROOMS
SERVICE ENTRANCE
LAUNDRY
HELPS DINING ROOM
CENTRAL KITCHEN
STORAGE
NORTH SERVING STATION
GARBAGE
STORAGE REFRIGERATORS
ICE STORAGE
SOUTH SERVING STATION
S.L.
SERVICE CORRIDOR
PATIENT'S ELEVATOR
ELEVATOR LOBBY
VISITOR'S ELEVATOR
CENTRAL STERILIZATION & LINEN ROOM
GENERAL LOBBY
ADMINISTRATION
LADIES WAITING ROOM
DOCTOR'S COAT ROOM
SUPT'S. OFFICE
GENERAL OFFICE
SUPERVISOR OF NURSES
NURSES SCHOOL OFFICE
CORRIDOR
VESTIBULE
MAIN ENTRANCE
CLASS ROOM
NURSES REST RM
CLASS ROOM
DIETITIAN'S OFFICE
SPECIAL DIETS
REFF.
TOILETS
HELPS'
NURSES DINING ROOM
SERVING ROOM
DOCTOR'S DINING RM.

Figure 10

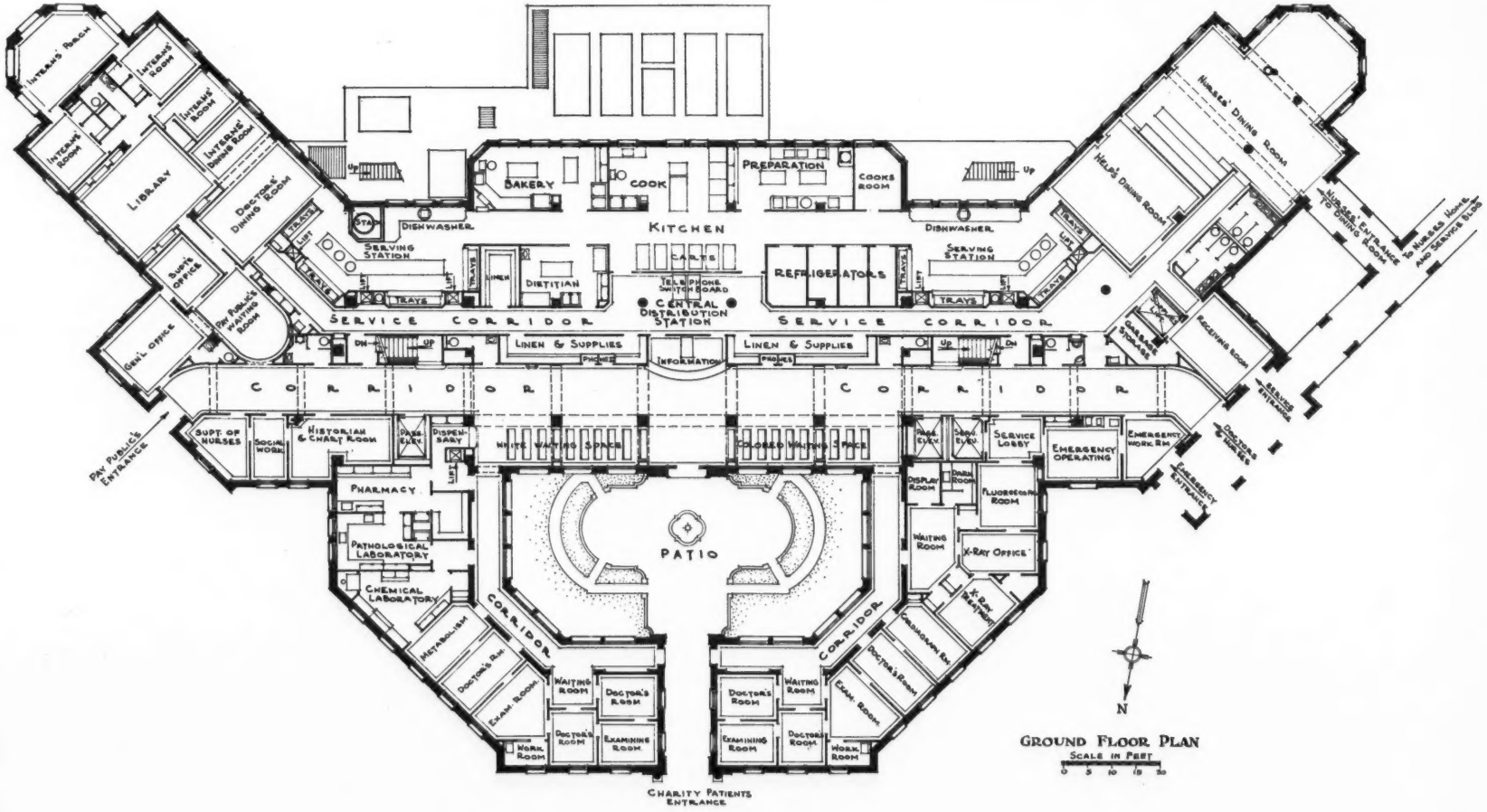

INTERNS' ROOM
INTERNS' ROOM
INTERNS' ROOM
INTERNS' ROOM
INTERNS' DINING ROOM
LIBRARY
DOCTORS' DINING ROOM
SUPT'S OFFICE
PAY PUBLIC'S WAITING ROOM
GEN'L OFFICE
PAY PUBLIC'S ENTRANCE
SUPT. OF NURSES
SOCIAL WORK
HISTORIAN & CHART ROOM
PARK. ELEV.
DISPENSARY
PHARMACY
PATHOLOGICAL LABORATORY
CHEMICAL LABORATORY
METABOLISM
DOCTOR'S RM.
EXAM. ROOM
WORK ROOM
WAITING ROOM
DOCTOR'S ROOM
EXAMINING ROOM
DOCTOR'S ROOM
EXAMINING ROOM
CORRIDOR
PATIO
CORRIDOR
DOCTORS' ROOM
WAITING ROOM
EXAM. ROOM
EXAMINING ROOM
DOCTOR'S ROOM
WORK ROOM
CHARITY PATIENTS ENTRANCE
WHITE WAITING SPACE
COLORED WAITING SPACE
PARK. ELEV.
SHOCK ELEV.
SERVICE LOBBY
EMERGENCY OPERATING
EMERGENCY WORK RM.
DISPLAY ROOM
DARK ROOM
FLUOROSCOPIC ROOM
WAITING ROOM
X-RAY OFFICE
X-RAY TREATMENT
CARDIOGRAPH RM.
DOCTOR'S ROOM
EXAM. ROOM
EMERGENCY ENTRANCE
DOCTORS & NURSES
SERVICE ENTRANCE
RECEIVING ROOM
GARAGE SPACE
NURSES' ENTRANCE TO DINING ROOM
NURSES' ENTRANCE TO NURSES HOME & SERVICE BLDG
NURSES' DINING ROOM
HELP'S DINING ROOM
COOKS ROOM
PREPARATION
BAKERY
COOK
KITCHEN
DISHWASHER
DISHWASHER
SERVING STATION
SERVING STATION
DIETITIAN
CARTS
REFRIGERATORS
TELEPHONE SWITCH BOARD
CENTRAL DISTRIBUTION STATION
SERVICE CORRIDOR
SERVICE CORRIDOR
LINEN & SUPPLIES
LINEN & SUPPLIES
INFORMATION
PHONES
PHONES
TRAYS
LIFT
DUMB WAITER
STAIR
UP
DN
C O R R I D O R
C O R R I D O R
N
GROUND FLOOR PLAN
SCALE IN FEET
0 5 10 15 20
FRONT

Figure 11

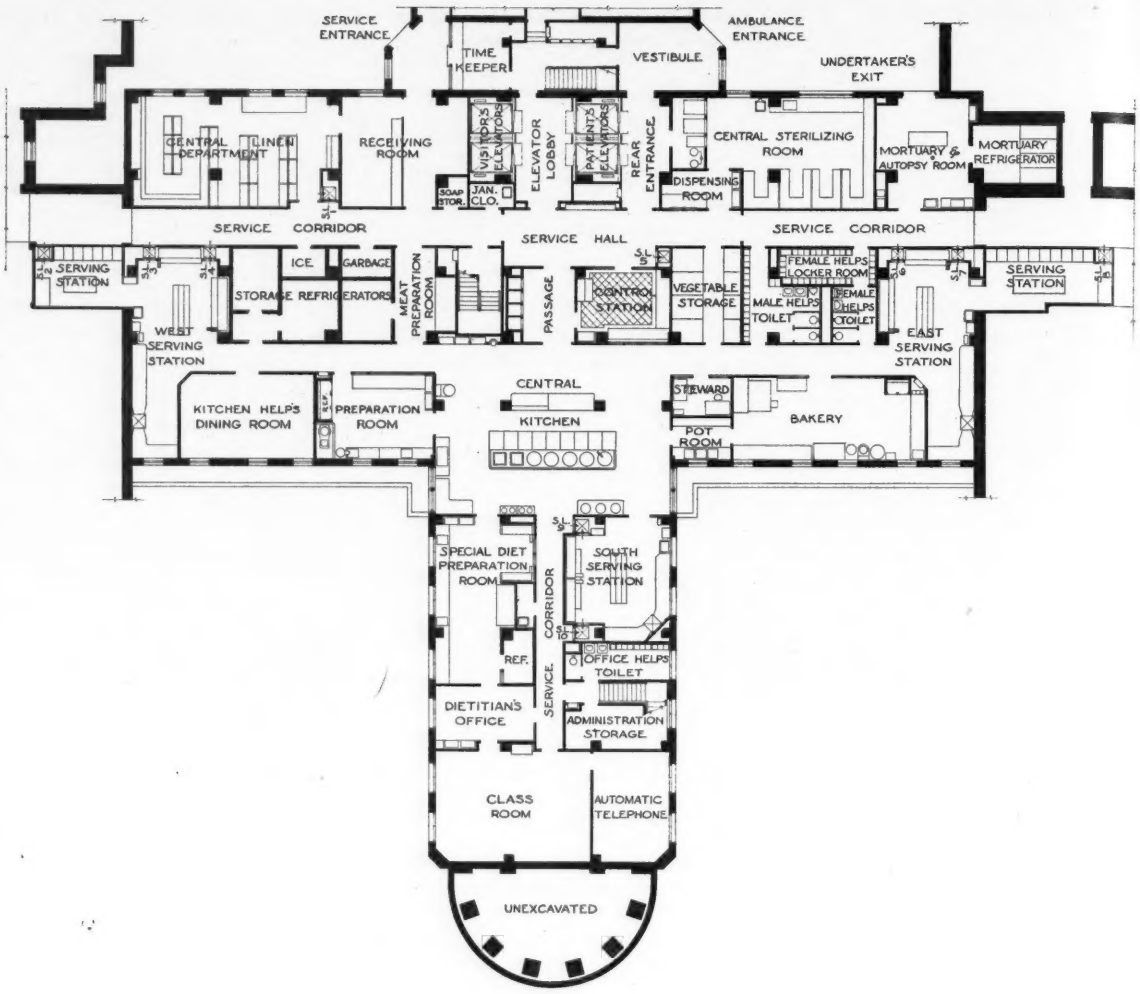


Figure 12

assembling on to the trays the various diet requirements of the patients. Central tray service does not need to curtail menu flexibility, if the serving stations are properly planned and equipped. Special trays can be brought from the diet kitchen to the serving stations and be sent to the various floors with the other trays.

Each serving station becomes a checking point and should be supervised by a dietitian. Arrange desk facilities for records and menu charts and provide telephone communication to all the nursing floors. The food lifts must be dispatched from the serving stations, in order to maintain control of them at all times. Ample storage space for dishes, regular and specials, to accommodate all the different services will minimize the carrying of dishes about the kitchen. Adjacent to each serving station there should be a dish washing room, fully equipped and ventilated. Visualize the handling of garbage from this point, and if possible, get it away from the dish washers without hauling it through the rest of the department.

The layout of the kitchen proper is not difficult, and every dietitian, cook, or chef can give valuable assistance if he will plan the food processing procedures and then arrange the equipment to accomplish the work with the minimum of steps. The size of the hospital determines how much segregation of work and equipment is desirable. Provide parking places for each piece of movable equipment, when it is not in use, and your kitchen can be kept clean and orderly at all times.

In conclusion, let us say that labor saving equipment will quickly pay for itself, and will assist in maintaining your regular standards by the elimination of much of the personal element. In the selection and purchase of equipment, endeavor to obtain the kind that has flexibility and can be

used for many procedures. Do not clutter up your kitchens with a lot of one purpose "gadgets," they get out of order, and consume more time in the make ready and clean-up than they save. Simplicity and substantial construction are far more important than modern design, shiny metal, and frills put on by the manufacturer to catch the prospect's attention.

Remember that the kitchen is just as important a factor in the hospital service as any other department, and while it is not normally visited by the patients the products turned out are very critically appraised. A kitchen placed off in a corner or in an undesirable location is reflected in the food service. Your dietitian may be able to get you over the hump but it takes hours of energy, patience, and costs you money every day. Furthermore, dietitians and doctors are becoming more friendly each year and they can and will get together for the patient's benefit, if you make the place of contact convenient. We do not hesitate to put the door to the dietitian's office directly off the Main Lobby if the plan will allow it.

If you are directly in charge of the food service in a hospital contemplating new construction or alterations, make yourself heard at the very beginning of the planning. Remember that your products will have to arrive in almost every nook and corner and you know how perishable food is and what delays can do to upset your efforts. Do not be pushed off in a corner or let yourself be given so much space to lay out. Be in on the whole plan.

International Hospital Tours

An interesting and economical European tour has been planned for those desiring to attend the International Hospital Congress, Paris, July 6 to 11, inclusive. At the request of the Committee on International Relations of the American Hospital Association the American Express Company is offering a series of carefully planned itineraries.

European travel, this summer, due to the Coronation, to business revival, and to other influences, will undoubtedly be heavy and steamship accommodations difficult to secure. The American Express has reserved for a limited period, accommodations for 25 persons. Those interested are advised to make early arrangements as this number of reservations may not be adequate.

All tours are based upon a sailing from New York on June 26 via Cunard-White Star M. V. "Britannic" with arrival in Paris on July 4. Leaving Paris on July 12, at the end of the Congress, the travelers will proceed to Lyons for inspection of its excellent hospitals, thence to Aix-les-Bains, the famous spa, via Geneva and Montreux to Leysin and the famous hospital of Dr. Rollier. Interlaken, Lucerne and the Grand Alpine trip will follow. Private automobile trip from Lucerne to Heidelberg and thence to Wiesbaden and down the Rhine to Cologne. There will be three days in Holland, including Amsterdam, The Hague, and Island of Marken. The travelers will cross the North Sea from the Hook of Holland to Harwich, England, arriving in London on July 25.

Those who must hurry will have three days for London and will sail from Southampton on the S. S. "Aquitania" on July 28, arriving in New York on August 3. The cost of this tour is $743.00 New York to New York.

Tour 1A, costing $695.00 gives an added two days to visit the Shakespeare Country, thence to Liverpool to sail on the S. S. "Scythia" arriving New York August 8.

Tour 1B, at $877.00 includes three days in London and a delightful motor coach trip of six days throughout the south of England. Return sailing from Southampton on August 4 by the S. S. *"Queen Mary"* arriving New York on August 9.

The New York office of the American Express Travel Service at 65 Broadway is preparing a detailed booklet about the trip and will distribute it for the International Relations Committee to interested persons.

Dr. Claude W. Munger will accompany the tour and will be in charge of the travel arrangements. Those who are arranging to attend the International Hospital Conference may be fully advised in connection with these tours by writing Dr. Claude W. Munger, president of the American Hospital Association, and superintendent of the Grasslands Hospital, Valhalla, New York.

Hospital Performance in 1936

THE survey of hospital performance in 1936 covering a cross section of 150 hospitals in the United States and Canada was initiated shortly after January 1. The analysis of the reports of the first fifty reporting hospitals was published in the February issue. The study was made with the purpose of securing authoritative data from the reporting hospitals covering increase or decrease of patient admissions, patient days, charity service, operating costs, bed occupancy, and the present bed occupancy.

Out of the 150 hospitals selected for this study 148 returned reports.

The following data pertains to 98 reporting hospitals. These hospitals are distributed as to ownership and control, in the three classes, voluntary associations, denominational, and tax-supported hospitals. Of the latter class the majority are city hospitals.

Included in this group of 98 hospitals with a total bed capacity of 23,572, there are 58 voluntary hospitals with a total capacity of 13,699 beds, 28 denominational hospitals with 5,142 beds and 12 tax supported hospitals with 3,731 beds. The range of bed capacities for the group was from 72 for the smallest to 1,050 for the largest.

The median hospital for the group would have 214 beds. It would have 8.25 per cent increase in admissions, 7.5 per cent increase in patient days. Its charity service for 1936 would be the same for 1935. It would experience an increase of 8.25 per cent in operating costs, and an increase of 4.8 per cent in bed occupancy. Its present bed occupancy would be 74 per cent.

The range for 1936 compared to 1935 reported for the entire group would be as follows. In general admissions, from 10.5 per cent decrease to 35.3 per cent increase in patient days from 5.07 per cent decrease to 38.5 per cent increase, in charity service from a 50 per cent decrease to 66.4 per cent increase. In operating costs from 11.2 per cent decrease to 45 per cent increase, in bed occupancy from 15.2 decrease to 25 per cent increase. The bed occupancy for 1936 ranges from 43.5 of the present bed capacity to 100 per cent.

Eleven hospitals reported a decrease in bed occupancy all but one of which reported a larger decrease in the percentage of charity service, than decrease in bed occupancy. Ten other hospitals reported no change in bed occupancy.

The median hospitals of the denominational group would have a bed capacity of 947, an increase of admissions of 12 per cent, increase in patient days 11 per cent, increase in charity service 4.5, an increase in operating costs of 12 per cent, and in bed occupancy 11.2 per cent. The present bed occupancy for the median hospital would be 74 per cent.

The median hospital for the group of voluntary hospitals would have a bed capacity of 227. An increase in patient admissions of 6.2 per cent and of patient days 6.2 per cent. It would have a decrease in charity service of .9 per cent. Its operating costs would be 7 per cent over 1935, and its bed occupancy would show an increase of 2.8 per cent. Its present bed occupancy would be 74.2 per cent.

Frequency of distribution of percentages of present bed occupancy.

The median hospital for the public hospitals, the tax-supported group would have a bed capacity of 311, an increase in patient admissions of 6 per cent, in patient days of 6.2 per cent; an increase in charity service 7.2 per cent. It would experience an increase of 4.5 per cent in operating costs. Its increase in bed occupancy of 4.7 per cent and its present bed occupancy would be 75.48 per cent.

The study of these 148 hospitals widely distributed throughout the United States and Canada of different types, of support, different classifications of service and located in areas varying from the small community to metropolitan centers, shows with numerically unimportant exceptions, a definite trend in increase of bed occupancy, in costs of operation, the number of patient days, and patient admissions. There seems to be an increase in charity service, although the

Table of frequency of percentage of distribution of increase or decrease of bed occupancy for 1936 over 1935.

—5. per cent	2	1-2	13	9-10	6	17-18	4
—3 —4 per cent	3	3-4	10	11-12	4	19-20	3
—1 —2 per cent	6	5-6	4	13-14	4	21-22	3
0	10	7-8	10	15-16	4	23-24	2

Percentage of Bed Occupancy	*Voluntary Hospitals*	*Denominational Hospitals*	*Other Hospitals*	*Total*
90-100 per cent	2	4	1	8
80- 89 per cent	15	7	1	23
70- 79 per cent	17	7	8	32
60- 69 per cent	12	7	2	21
50- 59 per cent	9	3	0	12
40- 49 per cent	2	0	0	2

impression of the study is that any such increase is not in proportion to the increase in patient admissions. In almost every instance, where the reporting hospitals has shown a decrease in bed occupancy, it has reported a more than proportionate decrease in charity service. The entire group with the exception of the tax supported hospitals, operated exclusively for the care of charity patients, indicates an increase in pay or part-pay patients, over any corresponding increase in charity service.

The study has been informative. It conveys to the hospital field the knowledge of the experiences of other institutions and form a fair basis of comparison of similar activity in their own hospitals. In its last analysis it is encouraging to the entire field, and can be accepted as an evidence that the present satisfactory trends will continue.

Again the Editor of *HOSPITALS* expresses his appreciation to the reporting hospitals for their fine co-operation in making available the information to accomplish this study.

Hospital	*Control*	*Bed Capacity*	*Percentage Increase in Admissions*	*Percentage Increase Patient Days*	*Percentage Increase Charity Service*	*Percentage Increase Operating Costs*	*Percentage Increase Bed Occupancy*	*Percentage Present Bed Occupancy*
51	Voluntary	303	12	9.9	—15.8	9.8	3.2	64.3
52	Church	315	16.9	30.7	1.03	14.1	Same	51.5
53	Voluntary	267	..	..	..	..	25	95
54	Voluntary	226	.3	22	— .4	45	.3	46.2
55	Voluntary	225	9.4	9.8	—10.7	11.7	9.8	93.2
56	Church	124	14	6	19	12.8	6	78.9
57	Voluntary	170	10	7	21	4	1.5	60
58	Voluntary	277	Same	1.2	Same	3.1	Same	72.2
59	Voluntary	290	7.4	4.3	5	8.2	4	74.3
60	Voluntary	225	—10.5	— 5.07	—34	— 3.1	— 5.2	57.2
61	Church	129	10	21	7	18	18	65
62	Voluntary	202	8	7	17	1	8	69
63	Voluntary	207	— .3	— 4	— 5.5	5.5	— 4	68.6
64	Voluntary	360	2.7	5.9	1.1	11.8	4.2	77
65	Church	150	11	11	15	8	10	70
66	Voluntary	125	7	7	Same	8	7	81
67	Voluntary	170	10	16.5	—50	18.9	17	80
68	Voluntary	152	8.5	10.4	— 8.5	13	8	77
69	Church	140	1.6	— 4.6	— 9	— 7	— 2	60
70	Voluntary	152	2	— 1.9	3	— 1.7	Same	56
71	Partnership	175	10	10	Same	11.5	10	98
72	County	143	28	9.5	15	8.5	12	75
73	Church	114	7	6.5	—15	12	6.6	85
74	Voluntary	595	5.9	3.2	—14.8	5.1	Same	86
75	Church	100	11.6	15	6	11.3	14.5	80
76	Voluntary	326	11.6	11.5	2.4	5.3	Same	63
77	Church	226	14.7	9.5	16.2	14.1	1.1	53.1
78	Voluntary	250	— 3.5	— .6	—13.2	3.3	Same	50
79	Voluntary	100	6.2	2.7	— 7.7	8	2.6	56
80	Church	125	9	11.6	—25	14.5	11.4	76.8
81	Voluntary	155	23.7	13	20	9	13.3	58
82	Voluntary	600	— .8	— .6	39	1.7	— .76	78
83	Voluntary	120	15	17	35	15	16	88
84	Church	149	14	8	Same	10	8.7	60
85	Church	330	35.3	38.5	66.4	23.5	19	80
86	Church	105	13.5	21	6	19	18	96
87	Voluntary	230	20	22	10	11	24.3	87

Hospital	Control	Bed Capacity	Percentage Increase in Admissions	Percentage Increase Patient Days	Percentage Increase Charity Service	Percentage Increase Operating Costs	Percentage Increase Bed Occupancy	Percentage Present Bed Occupancy
88	Voluntary	225	Same	— 4.1	— 8.5	4.9	— 4.4	67.3
89	Church	138	3.1	3.4	— 2.9	13.7	3.1	65.4
90	Voluntary	454	2	— 1	5	3.5	— 1	70
91	Church	145	11.6	1.8	4	4.4	2.5	69
92	Church	191	13	14	.06	15	10	89.5
93	Voluntary	350	5.9	8	8	11	3.7	52.1
94	Voluntary	232	3.6	— .3	—34.2	— 1.3	Same	82
95	Voluntary	180	5.2	1.8	22.4	3.5	.1	66
96	Church	229	16	18	11	16	17	98
97	Voluntary	325	13	1.2	14.5	4	.5	86.3
98	Voluntary	141	1.2	— 1.3	—50	5.7	.5	50
99	Voluntary	175	17.5	15.7	21	10.6	16.5	77
100	Voluntary	780	4.7	— 1	— .4	2.8	— .5	75
101	Voluntary	225	5.3	6.8	4.8	10.8	7	80.5
102	City	681	— 3.8	— 2.61	Same	3.2	— 2.1	77
103	State	280	— 2.7	— 3.44	— 1.85	— 2.5	2.13	65
104	Voluntary	290	4.7	— .1	9.1	5.9	.6	69.2
105	Voluntary	135	8.6	1.1	—12.7	20	.2	69
106	Voluntary	112	4.7	8.9	10	8.5	.8	85
107	Voluntary	213	7.5	4.1	— 1	2.5	2.5	66
108	Church	220	14	18	18	.03	20	70
109	Voluntary	160	— 1.9	— .4	—27.6	2.8	— 4.3	90
110	Church	114	9	13	5	7	12.5	90
111	Church	425	2.2	2.2	10	Same	21.5	82
112	Church	160	12	3	Same	4	13	65
113	Voluntary	215	10	16	12	7	8.9	73.9
114	Voluntary	142	12.2	21.5	—17.6	—11.2	—15.7	87.1
115	Voluntary	136	Same	Same	— 9	7.7	3	79
116	Voluntary	150	12	15.9	— 2.7	5.5	15.6	55.8
117	Voluntary	311	11.6	8	3.2	10.7	Same	85
118	City	72	2	11	21.5	8.5	3.5	90
119	Voluntary	270	10	9.5	— 4	Same	10	75
120	Voluntary	170	24	23	— 9	18	22.5	81
121	Voluntary	262	7.5	11	Same	8.9	10.7	65.8
122	Church	244	17.8	10.9	51.7	10.46	8.68	100
123	Voluntary	300	3	4.5	7.9	5.1	5	53
124	Church	160	..	..	—31	8.6	11	..
125	Church	87	7	7	—37	14	4.5	74
126	Church	140	12	11.0	Same	25	14	71
127	Voluntary	270	5.2	6.4	—23.7	8.3	4	70
128	Voluntary	350	6	1.5	—35	9.5	1.5	95.4
129	Church	392	10.0	14.69	11.94	16.94	15.31	80
130	Church	110	.0	20	Same	.04	20	63
131	Corporation	102	1.4	6.6	.5	— .8	2.8	79.88
132	City	350	11.0	8	7	7.5	8	74
133	Church	100	21	22.9	—26.5	12	22.2	55
134	Voluntary	141	3.1	4.9	8.6	9.3	3.4	72.5
135	Private	1050	12.4	8.2	11.1	12	3.5	80
136	City	200	5.7	5.1	4.7	.29	5.34	72.5
137	Voluntary	400	2.8	1.1	—14.2	6.8	.7	79
138	Voluntary	450	.08	.03	— 1	.05	.08	84
139	Corporation	78	2.0	9.8	19.4	3.1	8.8	68.4
140	Church	300	16.0	7	13	11	4.6	89.3
141	Voluntary	142	10	10	20	16	8.5	78
142	Voluntary	100	9	8	8	9.2	12.5	43.5
143	Voluntary	320	16	16	— .9	15	16	64
144	Municipal	267	13.0	8.0	Same	Same	Same	75.0
145	Voluntary	371	18.7	10.9	1.2	2	11	87
146	Voluntary	423	— .01	— .03	—48	1.6	.7	79
147	Voluntary	467	— .08	.01	— .06	9.3	1	84
148	City	333	1.9	4.0	Same	2.5	Same	71

Equipment for the Treatment of Fractures in Hospitals

A. WILLIAM REGGIO, M.D., Chairman

State Fracture Committee, Boston, Massachusetts

IT IS NOT such a simple matter to set down just what equipment should be available in any hospital for the proper treatment of fractures. Of course every hospital gets a certain number of fractures annually and should be adequately equipped for handling emergencies. Many of the smaller hospitals, however, should transfer the serious cases to larger hospitals, where the facilities for carrying the treatment through to its conclusion are more adequate.

In no way is this any reflection on the smaller hospital, because adequate equipment for handling all types of cases from the time of admission to discharge, is expensive and in some communities beyond their reach.

Necessary Equipment

Equipment—in this sense—is meant for example, not only the absolutely indispensable x-ray outfit but also the fluoroscopic table. There should be a trained person to run the apparatus, while the surgeon gives his entire attention to the patient. Then there is the Balkan Frame; apparatus for skeletal traction; special instruments for fracture work; a workshop for making special apparatus and the very important convalescent splints; and facilities for physiotherapy. A system for following up the patient after his discharge from the hospital, is advisable to avoid possible trouble, due to his not reporting back to the hospital while the case is still under treatment.

The above sounds like a very formidable array of requirements for the adequate handling of fractures. It is! But without adequate equipment the best results cannot be obtained in all types of fractures and if any hospital is going to treat all types of fractures it must be adequately equipped, otherwise its staff cannot do the best work.

This does not mean that the equipment must necessarily be the most expensive. Far from it. For example, a Balkan Frame made out of 2″x1″ white pine and some screw clamps is just as efficient as the most expensive fracture bed. Some 15 or 20 Balkan Frames can be made for the price of one commercial fracture bed. Possibly the appearance of the ward is enhanced by the handsome display of fracture beds as contrasted with the less pretentious appearing wooden Balkan Frame. But will the fractured femur do any better in one bed than in the other? The answer is obviously NO! It is not always the expensive bed that makes the good result, it is the treatment behind the *adequate* bed that counts. This holds true all the way through as regards proper equipment for handling fractures.

How to Determine the Proper Equipment

How is any particular hospital going to determine what the proper equipment for that particular hospital should be? There are two ways of setting about this problem. The first and the correct way is to have the staff who handle the fractures determine their requirements and then consult with the superintendent or the Trustees, advising what equipment is essential and necessary. This is the only satisfactory method.

The alternative and incorrect way is for the superintendent or trustees to equip the hospital with all the latest catalogue and salesman paraphernalia, much of which will probably never be used because nobody will know just how to use it! This sounds cynical but you may rest assured it is not—it is just plain fact. If you doubt this statement all you need do is to go to the basement of practically any hospital and inspect the discarded gadgets that are on display there. Many of them quite expensive but not used by the staff.

There are many devices for the treatment of fractures on the market that are masterpieces of ingenuity; the only trouble being that most men treating fractures are not expert mechanics and are quite at a loss as to how to use the gadgets to obtain the results claimed for their use. They are all expensive, readily get out of repair, and when used incorrectly tend to make trouble instead of simplifying matters. The salesman can explain perfectly just how the thing works—when there is no patient present on whom to work it. Put the machine to actual use and some-

Presented at the New England Hospital Association Meeting, Boston, Massachusetts, February 25, 26, 27, 1937.

how it doesn't seem to be quite as simple as the demonstration by the salesman.

What is meant by this seeming discourtesy to some types of apparatus is simply this, that the simpler the apparatus used, which will accomplish the desired result, the better for all concerned—patient, doctor, and hospital!

Adequate Equipment—Not Makeshift—Must Be Available

On the other hand it is a false economy to force the doctor into using make-shifts because adequate equipment is not available. Again, it is bad for the patient, the doctor, and the hospital because it is unfair to all three, especially to the patient who must always be the first consideration. The patient may quite possibly suffer unnecessarily, which might have been avoided by the use of adequate apparatus. It is not fair to expect a man to treat successfully a fracture in a child with equipment designed for an adult or vice versa—yet this condition is not unknown. It is an example of false economy.

Maintenance of the Equipment

Another important consideration is the maintenance of all such equipment in perfect working order. An expensive instrument may easily be ruined and made useless by careless handling or the neglect to keep it in perfect working order. Even though it may be infrequently used, it should be treated carefully so that it will be instantly available when the occasion arises.

Some Antiquated Equipment

It is quite possible that the staff occasionally may seem to be quite unreasonable in their requests for new equipment. This has been known to occur! "But only a few years ago you had us buy the such-and-such apparatus and now you want the other one. Why can't you use the one you have?" In such instances the matter can usually be very easily settled by talking it over together.

Equipment does become out of date relatively soon, due to our progress in treating fractures as better methods are devised. Only a short time ago the Steinman pin and the Ice tongs were the accepted instruments for use in certain skeletal traction. These have now been largely replaced by the Kirschner wire method. This results in the discarding of old equipment and the purchasing of new. Expensive? Yes! but one of the *necessary* expenditures to keep abreast of advances in treatment. It is not necessary to buy a motor outfit for inserting the Kirschner wire, since the much less expensive and equally efficient hand-drill is adequate. In this particular instance, for example, the consultation of superintendent or Trustees with the staff will result in the acquisition of adequate equipment at minimum expense.

Staff Should Be Conferred With Before Purchasing Equipment

All of this brings us down to what may be summed up in a few words. Namely, the suggestion that Trustees and superintendents should not attempt to provide equipment in their hospitals for the treatment of fractures, without first conferring with the members of the staff as to the needs of the hospital and the staff.

This is wise economy and also protects the hospital from purchasing unnecessary equipment that some member of the staff *thinks* he needs! It works both ways!

To become somewhat more specific as regards the needs of various hospitals, it is necessary to consider the type of work done and the location. The automobile has provided a tremendous number of emergency fractures and their prompt handling and treatment demand adequate equipment from the very beginning if good results are to be obtained.

Equipping the Ambulance for Fracture Cases

If the hospital has an ambulance it should be equipped for the correct handling of the case for which it is sent out. As a minimum there should be available a stretcher; two Thomas leg splints for adult and child (the type applicable to either leg); two Thomas-Murray arm splints and, of course, slings, bandages, etc., which are an obvious necessity. In case the hospital has no ambulance of its own, it should then see to it that the ambulance in the vicinity, which it uses, is adequately equipped.

Every hospital, no matter how small or where located, should have this minimum of equipment available for the emergency which may at any time come to it. Then the patient will receive adequate emergency treatment which will permit his safe transfer, if necessary, to the larger hospital.

The big hospital which is known to take all types of fractures has not, or at any rate should not have the serious problem of adequate equipment. This type of hospital has a large staff treating its fractures, it needs cover the entire range of equipment and its only problem is the wise purchase of equipment, so as not to run into unnecessary expense.

The intermediate type of hospital is one where

the real difficulty is encountered. What are the physical needs of such a hospital for the treatment of fractures? Remember that by "The treatment of fractures" is meant the complete treatment of any fracture from the very beginning to the final, end-result. This may involve a matter of treatment anywhere from a few weeks to a year or more. Is the hospital ready to take on such cases? Is it adequately equipped to care for the best interests of the patient? Has it the staff; x-ray equnpment; apparatus necessary for immediate treatment; special instruments for operative cases; facilities for making special convalescent splints; needs for physiotherapy, and a system of following up the patient until finally discharged from the clinic? This is a formidable array of requirements for any hospital that takes all types of fractures as they come to its doors. But these are questions which must be answered by the hospital if it is honestly interested in improving the treatment of fractures in its locality.

Institutional Mortality in 26 General Hospitals in Wisconsin With Bed Capacities of 100 Upwards

THE institutional mortality in hospitals receiving general acute medical and surgical cases is a fair index of the professional service of the institution. The mortality curve is influenced upwards, when a considerable portion of the hospitals' beds are allocated for the care of chronic and incurable patients.

The general hospitals of the state of Wisconsin of 100 beds or over are modern institutions with adequate equipment and well trained and experienced staffs. When the study of the institutional mortality in this group was undertaken at the request of the superintendent of one of Wisconsin's general hospitals it was anticipated that the rate in these institutions would compare favorably with any similarly typed group wherever located. And so it proved.

Twenty-six general hospitals of over 100 beds, reporting, had a total number of admissions for 1936 of 99,260 patients, among which there were 3,814 institutional deaths, with the satisfactorily low institutional rate of 3.84 per cent. The range in rate was from 1.11 per cent in a hospital having 1,995 admissions with 22 deaths to a rate of 5.8 per cent in an institution having 2,093 admissions and 121 deaths. It is interesting to note that the hospital having the largest number of admissions (11,253) had 355 deaths, and the low mortality rate of 3.13 per cent or 0.71 per cent less than the average for the group.

The study shows that 13 of the reporting hospitals had an average of less than 3.84, the average for the entire group, and thirteen hospitals had a rate higher than the average for the group.

Admissions, Deaths, and Percentages of Institutional Mortality of Eleven General Hospitals of Wisconsin Containing One Hundred Beds and Over for the Year 1936

Hospital Number	*Number of Admissions*	*Number of Deaths*	*Institutional Mortality Percentages*
1	2,283	93	4.14
2	3,883	179	4.6
3	3,775	150	4.0
4	4,750	211	4.66
5	1,995	22	1.11
6	2,547	61	2.41
7	3,951	198	3.3
8	6,845	183	2.66
9	3,780	140	3.7
10	4,670	176	3.7
11	4,914	240	4.9
12	2,792	111	4.0
13	6,097	306	5.02
14	2,375	64	2.7
15	1,488	62	4.1
16	7,262	212	2.9
17	11,253	355	3.13
18	2,093	121	5.8
19	3,336	149	4.5
20	1,248	44	3.5
21	2,396	110	4.6
22	2,542	114	4.5
23	3,950	142	3.6
24	2,662	141	5.3
25	3,255	121	3.4
26	3,118	109	3.5
The Totals:	99,260	3,814	3.84*

*Per cent average institutional Mortality rate for the group.

Maintenance of Plumbing for the Hospital

L. B. STINE,
Hospital Plumbing Section, Crane Company, Chicago, Illinois

NO INSTITUTION is more utterly dependent upon "word of mouth" advertising than the institution with which you are connected. And what do the patients who step forth from your door say? Their impressions are based upon your staff and personnel, their skill and kindly attention, upon the efficiency with which your institution is operated, and upon the adequacy of equipment used. This last is extremely important since it helps to make the tasks of the other easier and more efficient.

Selection of Plumbing Equipment Most Important

Since your plumbing is fixed equipment, the first step to achieve the efficient results at a minimum of maintenance expense must necessarily be in the initial selection of such equipment. The progress of science is constantly calling for new engineering practices in the development of mechanical equipment for the hospital. This is necessary to meet the needs of advanced technique called for in the safeguarding of the patient, and to assist the staff and personnel in carrying on in a smooth, efficient, and economical manner twenty-four hours per day. Hence, when replacing any of the present or obsolete plumbing equipment, it is of equal importance to select items best suited for the purpose and service required of them to assure the utmost in economy. The acceptance by many hospital superintendents of the ordinary garden variety of commercial fixtures, when especially designed, scientific equipment was available, has proven a very costly experience, to say nothing of the impairment of service.

To stress further this point in the terms of actual expenditures based on a recent unbiased survey of hospitals of variable bed capacities, geographically situated, it was disclosed that the average annual expenditure for maintenance and betterment of plumbing and heating appliances averaged approximately $9.35 per bed. On the basis of a 100-bed hospital, this would amount to $9,350 per year, to say nothing of the additional cost of heating water for domestic use, a great deal of which is wasted through faulty plumbing appliances. Certainly such a stupendous annual expenditure justifies a careful scrutiny to ascertain if each unit purchased affords the utmost in uninterrupted service, and to aid the personnel and staff to carry on in a most efficient manner.

As an example; the very finest sanitary vitreous china surgeons' scrub-up sink, which is impervious to checking, crazing, or staining is only as good as the weakest unit assembled to it, necessary to complete its function. If the knee-operated water supply mixing valve lacks means for proper adjustment to suit available water temperatures, its function will be impaired to the extent of failing to mix and deliver water at the desired temperature. Likewise, if the very finest knee-operated water supply mixing valve is not arranged with the operating stirrup at the correct height from the floor and in a correct position in relation to the location of the spray over the sink, operating the valve is made very difficult and inconvenient to the user—all of which affects the general utility of the sink itself.

If the spray over the sink is without easy accessibility for cleaning and is constantly becoming clogged with lime deposits, thereby constantly splashing water on the surgeon, the sink proves very unsatisfactory.

If the gooseneck water supply spout is not properly located in relation to the depth and size of the sink, the surgeon cannot properly rinse his arms without touching some unsterile portion of the sink. Hence, the value of the sink is dangerously impaired.

If the waste outlet is not properly safeguarded against brush bristles passing through, a stoppage of the waste lines will frequently place the sink out of service, to say nothing of the expense and annoyance of removing the obstruction.

These are just a few important fundamentals as they apply to a surgeon's scrub-up sink. Similar factors apply equally to all institutional mechanical equipment. When procuring plumbing appliances either for new installations or for replacement purposes, their special function must be given consideration if utmost economy and preservation of fixed equipment is to be achieved.

Effect of Water Pressures and Temperatures on Plumbing

A further very important factor to be considered when procuring new equipment to be used for a specialized service, is the available water pressures and temperatures. Many of these specialized type fixtures, to function satisfactorily, require definite volume of water per minute at certain specific pressures and temperatures. Only too frequently a high grade plumbing appliance is

condemned because the desired result is not attained, when it is due to lack of these requirements. If after such a fixture is installed it is found it cannot be used because of its unsatisfactory function, it becomes an overhead expense, as idle equipment would be in any manufacturing or business institution and no institution could hope to operate its fixed equipment in an economical manner with many such appliances.

Surveys made of hospitals and kindred institutions indicate a water consumption of approximately 200 gallons per day per patient. A 100-bed hospital would consume approximately 20,000 gallons of water per day. How much of this is wasted? Basing our calculations on a water rate of $4.60 per 20,000 gallons, a single leak approximating 1/32-inch stream, which is about the size of a pencil point, would cost your institution $18.04 per year. Just picture what this cost would be if a number of faucets or valves were leaking throughout the building. Closets, too, are frequently found leaking, which are unobserved because of their peculiar construction. If your institution is not charged for the water consumed by the community in which you are located, you may feel this is of no great concern. But, even so, let us see if wasted water costs you anything.

Approximately one-half of the water consumed must be heated. To heat 10,000 gallons of water per day through a temperature rise of 100 degrees Fahrenheit, using soft coal, at approximately 12,500 B.T.U. heat value, costing $7.00 per ton, would cost approximately $3.64 per day, or $1,328.60 per year, and to operate a laundry, this figure would be much larger. Hence, if only 1/10 of the amount indicated by these figures is wasted due to faucets or valves leaking, the loss would be in actual dollars equal to $132.86, to mention nothing of new equipment necessitated due to the impairment caused by the constant leaking (which tends to cut and distort valves and faucets), which would be many times the cost of heating the water.

Frequent Check-ups Necessary

The nature of the hospital demands that all plumbing equipment be in good working order, ready to function day or night. An institution can be assured of this uninterrupted service only by having frequent check-ups made at definite intervals. In this manner the slightest symptoms of imperfections in performance can be detected, diagnosed, and frequently corrected at little or no expense, and by so doing in the early stages, the life of the fixture is preserved, to say nothing of the savings effected in preventing the waste of water or steam.

The construction of the ordinary valve and faucet is such that to avoid what is known as "wire cutting," it should be either wide open or closed tightly. If the service of such a valve calls for restricted flow of steam or water, the particular valve should be one of a type designed and built for such a service, if utmost economy is to be achieved. When a dripping faucet is observed, if it is given attention immediately, it frequently requires nothing more than a new disc, but if left unattended for a considerable length of time, due to the cutting effect of the water passing through the restricted area, it is likely to be found so impaired that it is beyond repair, necessitating a complete new fixture.

The Importance of Hot Water Temperature Control

The above figures might also serve to stress the importance of hot water temperature control. Many institutions heat their water for domestic purposes to extremely high temperatures for no apparent reason, which necessitates mixing cold water with the hot to cool it to a suitable temperature for use. The higher the temperature to which the water is heated, naturally, the greater the cost of the fuel, and unnecessary impairment of the efficiency of the plumbing equipment, due to a lime deposit which takes place when water is heated to exceed approximately 150 degrees Fahrenheit. This lime deposit frequently causes a loss in water pressure, making it extremely difficult at certain intervals to obtain sufficient water at the various fixtures throughout the building. Occasionally complete stoppage of the water supply lines can be traced to this condition, necessitating their removal sooner or later, which frequently proves very costly, in addition to causing the annoyance of tearing up floors and into walls. This can all be avoided by the use of proper thermostatic temperature control on the heating unit of the hot water supply tank, and having the circulating hot water supply system properly insulated.

The subject title covers such a broad scope a book might easily have been written about it. I have only attempted to touch briefly on the high spots, with the one thought in mind to point out some of the important fundamentals as related to the hospital, the significance of which should place further emphasis on the responsibility which all manufacturers of this type equipment should accept. When hospitals are replacing or adding to their present equipment, such appliances should be selected which when properly installed, will further advance the progress of the patients and effect a smooth, efficient, economical service for the institution.

This, I believe, is the foundation of the preservation from an economy viewpoint, as it relates to plumbing for the hospital.

Maintenance Painting in the Hospital

W. J. CHAMPION, Technical Representative
E. I. du Pont de Nemours & Company, Boston, Massachusetts

MAINTENANCE painting in the hospital, whether it is large or small, resolves itself around three major factors:

First: The selection of the paint which will be most suitable for each particular surface.

Second: The proper application of the paint material selected.

Third: Close supervision and subsequent care given the painted surfaces by the housekeeping and maintenance departments.

Because of the important changes and improvements that constantly take place in the paint industry, it is more of a necessity now than ever before to cooperate closely with a reliable paint manufacturer in the selection of your paint materials. Needless to say, the only way to make sure your paint is properly applied is by the employment of a capable painter. Interior and exterior paints, can be rightly expected to look better and to outlast their predecessors, because of the introduction of improved pigments and more durable vehicles in modern paint formulation. Unfortunately careless handling of rolling equipment or a too generous application of cleaning solution often times decreases the normal life expectancy of the paint film. Constant supervision and education of employees is the only practical solution to this phase of the maintenance problem.

The Maintenance Department—Its Efficient Operation

Regardless of the size of your organization, the efficient operation of your maintenance department is largely dependent upon the adequacy of your personnel and equipment supplemented by a rigid schedule of supervision and inspection.

While it is theoretically possible to predict with some accuracy the normal life of a given paint film, it is seldom practical to work up a paint schedule that can be economically followed over a period of years. A paint program based on periodical inspections will save you money in the end. Examine all surfaces for wear once or twice a year, and if the paint is in good condition or has not lost its decorative value, do not paint. May I also suggest that you have a technical paint service man accompany you on these paint inspection trips. Select a paint manufacturer who will be glad to furnish such a technician as part of its service. Substantial savings in your paint maintenance bill will often result from his recommendations and suggestions.

It is almost superfluous for me to say, the best paint is the cheapest in the long run. While paint requirements for any particular hospital may vary to some extent, experience has clearly demonstrated that quality materials mean lower maintenance costs and a more satisfactory looking job. The only dependable buying policy is, therefore, to specify and standardize on well-proven brands of prepared paint.

Let us consider for a moment just what is expected from a paint film in the way of performance. Here is a liquid that must be easily and quickly applied to any surface, yet must dry to a hard durable finish soon after application; then, although no thicker than a piece of wrapping paper, this paint skin is expected to protect the surface and retain its good appearance for a number of years—regardless of weather conditions or repeated washings.

Six Important Factors in Selecting Paint

To be truly serviceable the paint film you select should decorate and protect your buildings and equipment for the longest period of time at the lowest cost. The most important questions to take into consideration in governing your paint choice are as follows:

Is it easy to apply?
Does it resist dirt collection?
Is it washable?
How long will it wear?
Does it provide a satisfactory surface for re-painting?
Is it desirable from a decorative standpoint?

Unfortunately, there is still an appreciable difference of opinion regarding the type of product which best fulfills the requirements I have just outlined. A gloss oil paint, as a rule, has poorer resistance to dirt collection, but is easier to clean than either a semi-gloss or flat wall paint. A flat paint offers the best surface for re-painting.

Treatment of Ceilings

Ceilings and upper walls in semi-gloss or egg-shell paint provide better illumination, collect less

Read before the New England Hospital Association at their annual meeting on February 25, 1937.

dust and are more desirable from a decorative point of view than a high gloss product. A high gloss paint should be confined to use on dadoes, trim-work, and other surfaces subject to hard wear and frequent washing. Do not use a high gloss oil paint on any surface that is not washed two or three times a year. High gloss oil paint collects dirt and dust readily and when soiled such a surface will absorb a great deal of light.

A few institutions still use calsomine for plaster ceilings because of its cheap first cost and ease of application; however, these advantages are outweighed by the fact that it can not be cleaned, has poor durability and re-decoration is frequent and messy. It has no sealing power to stop suction, hence its porous surface collects a large amount of dirt. Furthermore, it darkens quickly in the presence of warm air currents. It costs but little more to apply an oil paint and its better appearance, durability, and washability more than compensate for its slightly higher cost.

A word regarding sound-proofed ceilings. If left unpainted the majority of acoustical products absorb a large quantity of light and dirt in addition to sound. However, a flat oil paint or a casein-lithopone paint offers the most practical solution to the maintenance of this type of product.

Re-decorating the Furniture

There is an increasing use of wooden furniture designed to create a more cheerful and home-like atmosphere for the private patient. However, metal furniture and equipment still predominate and must be re-decorated periodically. Brush application is the most practical method of re-painting furniture except in a few of the larger institutions where spray equipment may be economically used. The maintenance of metal furniture, as well as all interior wall surfaces, has been simplified greatly in recent years through the introduction of synthetic resin enamels having remarkable resistance to chipping and abrasion. These synthetic finishes dry to a hard yet flexible film and will retain their beauty for a long time.

Outside Painting

It is false economy to neglect outside painting. Make a careful inspection of all exposed metal and wood surfaces every year to make certain paint films are standing up. It is well to bear in mind that paint does not wear out evenly. Horizontal and sloping surfaces wear out before vertical ones, and the south exposures before the other exposures. In New England, from a protection standpoint, an outside painting cycle may be as long as five to six years with liberal touch-ups every three years. This schedule will permit a good paint to fail by slow chalking and thus prevent building up a heavy paint film. From an aesthetic standpoint it may be advisable to paint oftener—possibly a two year touch-up and a complete job every four or five years. Trim work will need some touching up every year.

It is pretty generally recognized that aluminum, copper, and other metallic paints reduce heat radiation. A radiator painted in a light tint blending with its background is from seventeen to twenty-five per cent more efficient than if painted with metallic paint. In the interest of economy and appearance make sure that your radiators are all painted in a light tint.

How to Keep the Paint Clean

To a large extent proper maintenance of buildings and equipment resolves itself around the care given to the few thousandths of an inch of protective film. Sometimes this thin coating is expected to perform the impossible, and we have an early paint failure. Cleanliness is all-important, and at the same time it is well to remember that when painted surfaces are properly cleaned, it is unnecessary to re-paint so often.

Use of a mild alkali cleanser and good soft sponges is recommended for washing walls. While desirable from a health standpoint, the merit of most wall washing machines now on the market is still an open question. To prevent the oxidized vegetable oils in paint from being attacked by the alkali in the cleanser, all washing should be immediately followed by a thorough rinsing with clean water. A cleanser with a harsh abrasive action will scratch the paint surface. Such scratch marks provide an excellent place for subsequent dirt and dust to lodge. Tri-sodium phosphate and soap powders, while effective cleansers, are sometimes used too generously or are only partially removed in the rinsing process, thus impairing the life of the paint film.

Inasmuch as labor represents approximately ninety-five per cent of your cleaning cost, quicker cleanings and lengthening the time between washings means real economy. The development of synthetic alkyd resin finishes, previously referred to, has done much to effect an economical solution to the cleaning problem. These synthetic finishes dry to a very hard finish from which it is far easier to remove grease and dirt. They will also withstand an indefinite number of cleanings. These alkyd enamels are coming into extremely wide use for maintenance purposes, and in many fields have already entirely replaced the old type of orthodox finishing material.

Finishing the Interiors

It has been estimated that the human eye can distinguish over 90,000 different colors. For-

tunately for the paint manufacturer the larger percentage of this number are not suitable as interior finish colors, because they absorb more light than they reflect. White has long been identified as a hospital color, because its use simplifies the detection of dirt. In recent years aesthetic and psychological reasons have led to a very substantial abandoment of white finishes for hospital maintenance. In a number of instances this trend away from the white appears to have been somewhat overdone. In the various utility rooms, kitchens, laundries, store rooms, and stairwells a white paint or a very light tint is essential for upper walls and ceilings. A white surface reflects more light than any colored surface, and if artificial lighting costs are to be kept at a minimum a white paint should be used. It is an established fact also that employees will do more and better work in a properly lighted room.

When it is desirable to use color for aesthetic reasons use light tints. As a rule ceilings should have a reflection factor of not less than seventy per cent. This is another way of saying that ceilings should be painted with ivory, light cream, white or off-white. Upper walls generally should not absorb more than fifty per cent of light. Suitable colors in addition to those mentioned above are beige, buff, yellow, and very delicate shades of gray, green, and blue. Walls below the eye level can be of moderately dark colors, bearing in mind, of course, the darker the color the more difficult it becomes to detect dirt.

In the past simplicity of color treatment and standardization on one or two colors was considered an adequate solution of the interior decoration problem. Fortunately the majority of hospital executives today recognize that color has a definite value when used discreetly for the purpose of creating a more home-like atmosphere for the patient.

In corridors, utility rooms, and wards the use of two-toned walls will help relieve eyestrain and simplify the maintenance problem. Where there are large areas of painted surface spots of a contrasting color should be introduced to eliminate the appearance of bareness. Private rooms that approach the home idea of a comfortable bedroom can not fail to have a beneficial mental effect on the patient. In your color treatment of walls and trim the less interesting drab buffs and grays should be replaced with color schemes of soft yellow, peach, rose pink, pale grays, and greens. Ceilings in a lighter tint create a cheerful impression. Three to six different colors or hues should offer sufficient color selection to satisfy both patient and hospital staff.

Solariums and reception rooms should be given a different color treatment than the bedrooms. Keep to the bright colors for both wall surfaces and furniture. Upper walls and ceiling of operating rooms, if painted, should be a soft white for maximum diffused light reflection and constant color value.

A final word of caution regarding color—remember the keynote of any color scheme should be simplicity, cheerfulness, and practicability.

The Co-operation of the Paint Industry With the Hospital

Scarcely a decade ago the paint industry was almost entirely guided by rule of thumb methods and limited to a blending and mixing of naturally occurring materials. Today, the paint industry has been reduced to an exact chemical science. Far reaching improvements have already been made, but the surface has barely been scratched particularly in the field of synthetic resins and emulsions.

Our research departments are working day in and day out to make better paint products. In this way the paint industry is doing its part to lower your maintenance costs.

Maurice Dubin Resigns as Director of Mount Sinai, Chicago

Maurice Dubin, director of Mount Sinai Hospital, Chicago, for the past seven years, has resigned. He plans to leave for an extended vacation and rest in Florida and California. Mr. Dubin will be back in Chicago in time to preside at the annual meeting of the Hospital Association of Illinois which is to be held in connection with the Tri-State Hospital Assembly (Illinois, Indiana, and Wisconsin Hospital Associations) in May. Mr. Dubin is president of the Hospital Association of Illinois and has served as executive secretary of the Tri-State Hospital Assembly for the past three meetings.

S. J. Barnes Retires

S. J. Barnes, superintendent of the United Hospital, Port Chester, New York, has resigned as superintendent of that institution. Previous to his taking charge of the United Hospital he was superintendent of Vassar Brothers Hospital, Poughkeepsie, for three and one-half years, and previous to that time he had been assistant superintendent of Pennsylvania Hospital, Philadelphia.

During his administration at the United Hospital, the Memorial Wing, increasing the institution's capacity from one hundred to two hundred beds, was added, and Barron Hall was built.

The Hospital Power Plant

ERNEST C. WHITAKER, Consulting Engineer
Boston, Massachusetts

BEING neither a physician nor a surgeon, I cannot tell what makes a man go, and what makes him stop going. I have, however, been associated for many years with those more than human institutions called hospitals, and I know something about what makes them go. I know that each must have a head, brains, hands, a soul, and other things human.

My association has, however, been with the mechanical side, that part which, though necessary, is often out of sight and out of mind.

You desire that your rooms be warm, although you may not be particularly interested in how they become so. You are dissatisfied if certain rooms are not ventilated, yet you care not what exhausts the air. You complain justifiably if there is not sufficient steam to operate your sterilizers, your kitchen, or your laundry, but that steam must come from somewhere.

It has been my responsibility to see that these and other mechanical services are provided, that they shall exist without attracting attention, and that they shall continue without interruption or failure, for a hospital can have neither holidays nor vacations.

Because of continual contact with this part of hospital planning, it is but natural that I should look upon the boiler plant as the heart, without which there can be no activity.

If you have any worries about your plant or equipment, it is in most instances due to the fact that you have inherited certain things which cannot now be easily altered, at least without expense. Such worries are individual problems, and although I know from experience what some of them are, time is too short to discuss them in detail.

Some of you in the future may be given the responsibility of building a new institution and would naturally desire to avoid all past mistakes of commission or omission. I cannot in a few moments advise you specifically, for each problem must be studied in detail.

In a small cottage hospital, it sometimes happens that there are no steam pressure requirements for laundry, kitchen, or even sterilizers. In such case, the plant becomes a simple house heating apparatus, which may be operated with a coal boiler, or perhaps a household oil burner.

As the establishment increases in size, high pressure steam becomes more necessary, even to the extent of requirements for the generation of electricity and refrigeration.

The ultimate size was reached in my experience, in New York-Cornell.

Advantages of Steam or Water

One of the first questions sometimes raised is the advantage of steam or water for heating.

Each new hospital is an individual problem, but in general, we may say this. For the very small hospital, requiring only a simple heating apparatus, probably hot water is the best. As we grow a little larger, and steam is required for other purposes, a modern system of vacuum steam heating is quite commonly the logical choice.

Use of Exhaust Steam

When we approach the very large institutions, where steam is required for the generation of electricity, there becomes available a quantity of exhaust steam at about five pounds pressure. If the hospital group is compact, this exhaust steam may be used directly for heating, supplementing it with such quantities of live steam as are necessary.

It sometimes happens, however, that the buildings extend for some distance from the plant, and it then becomes advisable to use the exhaust steam to heat water, which is in turn pumped to the several radiators.

This method of forced hot water heating is used in New York, Cornell, Columbia, Presbyterian, Chelsea Naval, and University of Virginia, all of which except Presbyterian generate their own electricity.

On the other hand, Lakeside, Cleveland; Pondville Cancer, Rockefeller, New York, Union Medical at Pekin, China, all have electric plants and heat by steam. Johns Hopkins has changed partly from water to steam. Those hospitals served by the Harvard Medical plant use steam.

Type, Size and Number of Boilers

The type, size, and number of boilers are also dependent upon the size of the hospital. While a cast iron heating boiler might be suitable for the cottage, a somewhat larger hospital might find its requirements best served by the steel firebox type, two of which have been recently installed at Leonard Morse, Natick.

For a still larger group, brickset tubular boilers fill the bill, and above this size, the watertube boiler is usually the only thing to use.

Presented at the New England Hospital Association meeting, Boston, Massachusetts, February 25, 26, 27, 1937.

The number and size of boilers in the plant should be carefully calculated.

In theory one boiler should be of a size capable of providing for the minimum summer load, and there should be as many boilers as are necessary to carry the maximum peak load, PLUS, one spare unit for emergency use when any one of the others is out for repairs.

In practice it is sometimes inadvisable to pick a unit as small as the minimum summer requirement, and it is not bad engineering to decide upon one of somewhat greater capacity, thus permitting a lesser number of boilers in the plant. Too many boilers are not justifiable.

Quite a bit of flexibility is available, because a modern boiler, properly set and equipped, may be made to develop up to 200 per cent of its nominal rated capacity, and 150 per cent to 175 per cent is very good practice.

But whether your plant calls for one or for five or more boilers, let me stress the fact that you *must* have one spare emergency boiler equal in size to one of the others.

Fuel

Now, what shall we use for fuel? Again, each case requires diagnosis and its own proper treatment.

I have said that the smallest heating boiler may be hand fired with coal or may be fitted with a household oil burner. It may be fitted with a household type of automatic stoker burning buckwheat hard coal. It may even be gas fired.

Fuels are of three general types:—gaseous, liquid, and solid.

Excepting in the natural gas regions we may practically eliminate gas entirely.

Oil is of several grades, and may be used in everything from the smallest to the largest boiler. The heavier grades are suitable for those plants which are operated by large and efficient mechanical crews in constant attendance.

Coal

Coal is also of several kinds and sizes, ranging from large lump to pea, buckwheat, rice, and powder.

Coal may be fired by hand, using stationary grates, shaking grates, or hand stokers.

We may shovel the coal by hand into the hopper of an overfeed or underfeed stoker, remove the ashes, and the stoker does the rest.

We may install machinery which will deliver the coal to the stoker and remove the ashes.

We may install pulverizing machinery which pounds the coal to a powder and blows it into the boiler, where it burns in suspension without grates or stokers.

I know of no hospital, off hand, which uses pulverized fuel, and it is suitable at present, if at all, only for the very large plants.

Oil, and the several other coal fired methods, are used very commonly.

New York—Cornell uses the heaviest oil, there being five oil burners under each of four boilers. Columbia-Presbyterian uses rice anthracite on mechanical stokers hand fed.

Rockefeller and Lakeside use stoker fired coal. Leonard Morse uses oil.

So you see, the size of the hospital doesn't seem to govern entirely the method of firing.

Just one more thing about fuel.

Sawdust is cheap, but no doctor would feed it to a man as a steady diet. There are cheap fuels, too, just as worthless for your boiler as sawdust is for man.

Now that you have a boiler plant, all equipped, fired, making steam, and an emergency unit if any boiler breaks down, you must carry the steam away, to your radiators, hot water tanks, sterilizers, kitchen, etc.

Suppose that a pipe bursts or a pump breaks down.

No heat in the wards, no heat in the operating room! No steam on the sterilizers!

Good engineering practice requires that a plant should be so designed that you have not only an emergency boiler, but that you so loop or bypass your piping system, that steam may be detoured in case of breakdown. Each vital part must be protected.

To be sure, man is equipped with two of almost everything vital except heart, but then, the permanent death of one man is not as serious as might be the temporary death of one hospital.

So we are provided with a plant, guarded against emergencies, operating nicely.

Shall we deny it the services of a physician when it develops an ailment, for plants do ail. They get leaky valves, holes or stoppages in pipes, excess acidity. They sometimes labor and groan.

Your plant must not be permitted to die.

It is so much easier to *keep* it perfect, than to start perhaps right where *Your* plant is now, and try to make it new. In plain words, this means a sum set aside each year for plant upkeep.

One word about the man you hold responsible for your plant—your operating engineer.

Yes, I know he's always wanting something there seems to be no need of. If he is not, watch him! He may be letting your plant die.

Admit that he doesn't know everything, admit that sometimes he is narrowed because he never sees anything but his own one plant. But please believe that in most cases he is interested and anxious to keep that plant operating, and you should show your appreciation by helping him.

Government vs. Voluntary Hospital

Carl E. McCombs, M.D.

Institute of Public Administration, New York City

IT would appear from the title of this article that the writer considers governmental and voluntary hospitals to be essentially antagonistic. They are not, of course, opposed in any basic sense, yet, as a recent contributor to *HOSPITALS* points out, the expansion of governmental hospital services is fast becoming a threat to the security and usefulness of the voluntary institutions.* Those who are urging national, state, and local government farther and farther into fields of health and social welfare, formerly regarded as peculiarly the province of voluntary agencies, apparently fail to recognize this fact. Along with such expansion of hospital services under government control, there is a steadily increasing demand upon the public purse. This makes it difficult, if not impossible, for many citizens to meet their tax obligations and at the same time contribute to voluntary activities for health and welfare betterment. Many generous folks who until recently, have been willing and continuing contributors to the current expenditures and endowment of voluntary hospitals, are beginning to ask why they should be called upon to pay from both pockets. If present trends toward the expansion of governmental health and welfare services continue, it is inevitable that the field of voluntary effort will be more and more restricted because of lack of financial support.

Conversion of Social Power Into State Power and Its Effect Upon Hospitals

It is well understood by all familiar with governmental activities, whether of local communities, states, or the national government, that still further expansion of government into new fields of public service for the betterment of our social and economic life is to be expected. Our rapidly changing modes of life and greater dependence on collective action, foster it, but not without danger to many of our social institutions.

A clear visioned and forceful writer has recently discussed the processes now going on of converting "social power" into "state power."* "The state," he says, "turns every contingency into a resource for accumulating power in itself, always at the expense of social power; and with this it develops a habit of acquiescence in the people. Already this is evident in America; the social power which resulted in the voluntary establishment, endowment, and maintenance of our finest hospital institutions is being steadily converted into state power. With this conversion of social power into state power, it is possible to visualize in the not too remote future, the almost conplete decay of the voluntary hospital system in America. That is, of course, if there is no change in the direction of present trends and no readjustment which will encourage the growth of governmental hospitals and voluntary hospitals as mutually dependent and complementary institutions.

If we could be assured that this conversion of social power into state power with respect to hospitals offered a guarantee of higher efficiency and better adaptation of human resources to human needs, we would all of us, I think, cheer it on. But there is ample evidence to prove that such is not and is not likely to be the outcome. Government is an inflexible and generally impersonal thing. The restrictions which it necessarily imposes upon its own organization and personnel in order to secure even a reasonable degree of efficiency under our system of political election, appointment, and legal observance, demand inflexibility. Civil service, a most necessary guarantee of efficiency and integrity in public service, inevitably imposes strict limitations upon social enterprise—and upon hospitals particularly.

Civil service is a better thing than political patronage for hospitals, and yet any one with experience in hospital administration knows that even such a desirable restriction of hospital personnel is often a decided handicap to wise humanitarian hospital management. In government, however, we must accept this principle even though we know it may not be in the best interest of hospitals, and therefore hospital patients, simply because there is no alternative to it, except political patronage.

Benefits Which Our Voluntary Hospital System Confers

It is unnecessary to comment here on the benefits to patient, physician, hospital workers, and community as a whole, which can best be secured through the efficient voluntary community hospital. Your contributor previously cited has covered this ground amply. There is, however, a point in

**What Can We Do for the Security of the Voluntary Hospital,* by Sister M. Mechtildis, superintendent of St. Anthony Hospital, Oklahoma City, Oklahoma. *HOSPITALS*, February, 1937.
**Our Enemy the State,* by Abert Jay Nock.

this connection which might well be further developed with respect to community interest in this matter. During the past twenty-five years, research in government has demonstrated clearly that under our political system, local government, based as it was upon the needs of our people in pioneer days, is no longer fitted for its task. Local governments in pioneer times were small and isolated, and little service was demanded by the people except protection of life and property. But as communities grew and transportation and communication brought them into close interrelation, a great variety of special services had to be developed for their safety, protection, education, health, and other things vital to individual and community life and happiness.

It has become evident that our ancient system of local government is not at all adapted to the modern scientific and technical requirements of public service, and so there has developed an urge for centralization of governmental powers and responsibility in larger units of government, better equipped for the work. Many functions of local government had to be moved upward from the town, village, or city to the county; others were moved from the county to the state, and then as in recent years, the states passed on certain of their responsibilities to the national government. The net result of this movement toward centralization in the interest of more efficient and economical governmental effort was, however, to devitalize considerably local community interest and community cooperative effort. In short the necessary centralization of governmental controls due to the demand for greater efficiency in spending public money, tended to deplete community resources of social power.

Largely because of this movement toward centralization of governmental controls, coupled with the demand for improved scientific techniques and facilities for sickness care, the hospital services of government likewise had to be designed, built, and administered with a view to service for large units. Small units of government acting under the restrictions which government imposes cannot maintain efficient local services simply because there are not sufficient tax resources available in the local units. Large city governments can do so, county governments in populous areas can do so, state governments and the national government likewise can do so, but the government of small local units cannot afford it from tax funds without subsidy. And national and state subsidies cannot be secured by local governments without relinquishing some of their freedom of action.

How Governmental Hospital Service Is Developed

The net result of this situation is that governmental hospital service which ought, I believe, to be developed in accordance with the particular needs of the given community or social group within it, has developed in a less intimate way. Governmental hospital service had to be designed, constructed, and directed to serve the composite need of many communities varying in type, need, and social and economic interest, or to adapt itself in a large city to the varying needs of a cosmopolitan city population in which a variety of religious, racial, social, economic, and other groups are represented. In consequence, government hospitals have proceeded to expand their services along all fronts so that the special needs of the various groups may be met. And with each expansion into special service fields, which hitherto were chiefly if not wholly within the province of the voluntary hospital, the resources of the latter in community support have been impaired, its opportunities as a community social agency narrowed, and its advancement impeded.

The ill effects of this change in the position of the voluntary hospital have been far-reaching. The transfer of responsibility for the care of the sick poor from the voluntary hospitals to governmental hospitals, plus the removal of such service from its immediate community contact in many places, has not been of advantage to the medical profession nor to the patient.

Governmental hospitals, except in the larger cities, have often been established in locations which though convenient for government, are inconvenient for many physicians. The best qualified physicians within the area served by the governmental hospitals are not in consequence able to serve as governmental hospital attendants. This is particularly noted in county hospitals which are remote from centers of population. Many physicians also are reluctant to serve in tax supported hospitals because they are ordinarily expected to do so without pay just as they would serve the voluntary hospital without pay. They hold that they should not be called upon both to pay taxes for the support of government hospitals and at the same time serve as attendants in them without compensation. They would and do give freely and abundantly of their time and ability to voluntary hospital work which they regard as philanthropic in character.

The voluntary community hospital offers the physicians better opportunity for education and enhancement of their private work in the particular communities where they live. As hospital attendants, their hospital patients are their fellow citizens in whom they have a direct personal inter-

est and whose needs, medical, social, economic, and otherwise, they know and understand. The attending physician in the governmental hospital of the large city, the county or the state, has rarely such personal, intimate understanding of his patients' problems. The voluntary community hospital, in other words, gives the physicians of that community a *quid pro quo* which the governmental hospital cannot offer. Can anyone doubt that the former cannot provide as effectively as the latter for the needs of the average patient?

Political Influence in Governmental Hospitals

Lest any reader think this argument is merely theoretical and not practical, the writer cites a quarter century of hospital experience, as house surgeon of a large metropolitan governmental hospital, as attending physician both in governmental and voluntary hospitals, as a practicing physician, and for the greater part of this period up to the present moment, a consultant in hospital and health service, governmental and otherwise. In saying this, he makes no pretension to authoritativeness or unusual expertness in appraising hospital problems. If these views do not find support among the great majority of hospital officials, physicians, nurses, and others having intimate acquaintance with hospital affairs, the writer will be happy to acknowledge the error of his ways. It is his experience, however, that outside of a few of the large metropolitan centers where govvernmental hospitals have been amply supported from public funds, and protected from the importunities of political patronage, the number of outstanding governmental general hospitals which have come under his observation throughout the United States can be numbered on the fingers of his two hands. The number of governmental hospitals is less than the number of voluntary hospitals as yet. But given an equal number of general hospitals, governmental and voluntary, the percentage of outstanding hospitals in the former group is statistically negligible when compared with that of the latter.

A few years ago, as a member of a special committee of the American Hospital Association, I labored with my associates to prepare a report on the status of county hospitals in the United States. County hospitals were chosen to illustrate government hospital facilities because there were so many of them and because they seemed to be the most typical of the governmental hospital type.

Information was sought by the committee on 347 county hospitals scattered throughout the country. The information sought was such as any good hospital ought to have been able to supply on short notice. It was requested in the name of the American Hospital Association and with the primary purpose of aiding all hospitals of the group. Eighty-two of the best county hospitals responded and the analysis of the information which they supplied showed that with two or three exceptions, even these best county hospitals were far inferior in every way to otherwise comparable voluntary hospitals.

The committee's general conclusion was that the deficiencies of the county hospitals were in the main due to lack of adequate financing. That is, of course, so customary in governmental hospitals whose budgets are based upon minimal standards of medical and nursing care, salary compensation, dietary, equipment, etc., as to be no news to anyone. But the committee went on to comment on other serious deficiencies which are not necessarily related to inadequate budgets. No amount of expenditure can offset the deficiencies due to irresponsibility and divided responsibility of administration, the influences of political patronage all along the line, the customary deplorable union of hospital and almshouse services, the lack of competent medical attending staffs, the lack of well trained nursing staffs and nursing educational opportunities, and the many other serious handicaps to good patient care.

Doubtless governmental hospitals are improving and will continue to improve in direct proportion to improvements in governmental personnel, higher standards in politics and better knowledge of hospital aims and ideals on the part of the people. We would all like to believe that the millennium is almost at hand; that shortly with more money, more intelligent officials, less politics in public service, and a better informed public, our government may safely be trusted to manage all social institutions. But this writer has a healthy skepticism about this forthcoming millennium. At least until it has arrived and there is visible, concrete evidence of it in our governments, he will continue to maintain that there still remain fields of human activity, interest, and service, such as the hospital field, in which social power is to be preferred to state power. Government is not ready yet to take over the tools which have been so expertly wielded by those whose primary interest was in the humanities instead of elections and party politics.

Increasing Demand for Better Hospital Service

One other point out of the many which thrust themselves sharply into this discussion should be especially noted. The extraordinary changes which have taken place in the domestic habits and modes of life of the American people during the past quarter century have brought a steadily

increasing public demand for more and better hospital service along all lines. Cases of illness and injury, mental and physical, which only a short time ago were cared for in patients' homes by their family doctors are now regarded, and rightly, as better off in well-conducted, well-equipped hospitals. Doctors and patients find it more satisfactory and more economical in the long run.

People are better informed generally about hospitals and no longer are subject to vague and silly fears of hospital abuse, neglect, or worse. Even before the depression period, in the golden days of our greatest prosperity, it was evident that prosperity encouraged wider hospitalization. And after noting the tremendous increase of the demand for hospitalization during the depression, it seems obvious that whether our people are rich or poor, they are going to demand more hospitals and better ones.

We can look forward, I think, to a great expansion of hospital facilities during the next few years. All of the old statistics of required hospital beds per 1,000 population may as well be thrown out of the window. What effect the existing provisions of the Social Security Act may have upon the trend toward increased hospitalization of the sick and injured, it is impossible to say, but the prediction is ventured that the Social Security Act will foster rather than impede it. And if, as seems likely, some plan of so-called health insurance, whether "socialized medicine" or not, becomes a part of the social security program, it is not a stretch of the imagination to prophesy that this too will still further increase the demand for hospital care. In theory, perhaps it should not, but having observed for many years that public health activities for sickness prevention have invariably resulted in the discovery of more people needing health protection, I am willing to wager that health insurance and sickness benefits will have the same result of discovering more sick in need of hospital care. So this question of where the responsibility for meeting the public demand for hospitalization should be lodged is an immediate one.

The question boils down to just this: Will the need of our people for efficient hospital care be better met by the further expansion of government into the hospital field, or by limitation of the government hospital field and a complementary development of voluntary hospital resources in those particular phases of hospital care of the sickness with which the latter is better able to deal? The answer to the first part of this double-barreled question is an unequivocal *No* from this correspondent, who just as unequivocally votes *Yes* on the second part.

Since we say *Yes* to the second part of the question, it is in order to suggest a plan which will at least serve as a basis for discussion by hospital authorities and leaders in the hospital field. We are in a stream of events which with respect to hospitals and other services for the betterment of human welfare cannot be controlled by merely taking thought. If anything is to be done to recreate social power as distinguished from state power in hospital service, there will need to be concerted and constructive planning and action by those most concerned. The writer has therefore attempted to set down the essential features of a plan, not the only one, nor necessarily the best one, but one which in his view offers a reasonable basis for compromise of the antagonistic forces now at work.

Classes of Patients for Whose Care the Government Should Provide

There are, as all health and hospital authorities know, certain types of sickness and need for medical care and supervision over which government must necessarily exercise supervision, regardless of the economic status of the patients. The question whether these patients are to be regarded as "public charges" or not is not the chief issue. The nature of their diseases, disorders, and defects are such as to require a degree of public control which only the government is competent to exercise, whether the patients are capable of self-support or not. These are: (1) mental diseases and defects; (2) communicable diseases including particularly tuberculosis and the venereal diseases; (3) chronic diseases and infirmities of the aged who are the subjects of government relief and protection under old age security laws; (4) other diseases and injuries for which government provides some special form of compensation to the victim. These are the chief categories of sickness and disability which now engage the attention of government and for which governmental controls have been set up in a majority of states. These should therefore form the basis for governmental hospitalization and provide the basic limitations of the governmental hospital enterprise. We do not mean that all patients of the types mentioned must necessarily be cared for in governmental hospitals, nor that governmental hospitals must in all cases limit themselves to the care of these special types of patient. Adjustments will have to be made here and there, depending upon the governmental and voluntary services available in the given community, and upon the financial resources of the community, but certainly it seems reasonable that governmental hospitals should adopt some basic policy such as that suggested.

Sphere of the Voluntary Hospital

If this general policy is adopted with respect to governmental hospitals, the voluntary hospitals, the voluntary hospitals should be given the opportunity to develop their services to the widest possible extent for the care of all other types of patient, medical, surgical, obstetrical, and other. In the interest of the security of the voluntary hospitals, proper arrangements should be made by the government to turn over to their care, all patients not coming within the special categories previously defined as requiring special governmental control—provided, of course, such voluntary hospital facilities are available and suitable for the purpsoe. Whether the patient of the voluntary hospital type is indigent or not is, as we have said, not the chief issue. The issue is rather: Is the patient of a type and in circumstances which permit the voluntary hospital to provide better than the governmental hospital for his needs and the community's social interest in him?

Government Should Remunerate Voluntary Hospitals for the Care of Indigent Patients

The following procedure is suggested for application in any governmental jurisdiction in which there are both governmental and voluntary hospital services: First, the governmental authorities responsible should provide appropriate and ample facilities for the care of those patients particularly requiring governmental control in the public interest. All other patients requiring governmental aid should be referred to the care of the voluntary hospitals up to the limits of their capacity and in accordance with the special facilities which they offer. To make this procedure most effective and productive voluntary hospitals maintaining proper standards of service for the care of the indigent sick should be approved for such purpose by the responsible governmental authority. Contracts should then be drawn up between the governmental authority and the voluntary hospital authorities providing adequate compensation to the latter for the services given. Such compensation should not be, in my judgment, merely a minimum payment for the bare necessities of hospital care—not, as is customary, merely payment based on an average patient day cost.

There is, as every hospital superintendent knows, wide variation in the actual cost of providing efficient care of patients, depending largely upon the special facilities, equipment, and supervision required for the individual patient, or sickness groups. It would perhaps be impracticable for governmental authorities to pay the actual cost of care of each individual patient, but through good accounting, it would be possible to determine within reasonable limits a fair rate of compensation for care of types of diseases, defect, accident, and injury. Furthermore, compensation to voluntary hospitals should take into account not only the basic cost of the service rendered, but should be a recognition by the governmental payor, that is, the taxpayer, that the voluntary hospital represents a community asset which should be fostered—whose value to the community is in no sense to be measured merely by its expenditure for current maintenance and operation.

Government Provisions for Out Patient Services Europeans

If it is essential to the governmental purpose that provisions be made for out-patient service to indigents, the voluntary hospitals should be encouraged and aided by the government in providing the necessary out-patient facilities. Similarly the government should pay an appropriate charge for the out-patient facilities used. Here again payment by the government should not be a mere minimum based on an average out-patient visit cost, but a fee based upon the actual cost of efficient service rendered to the special types of patient treated. I should include all medical social service activities and follow up inquiry necessary to insure that the out-patient gets full benefit from the expenditure which the government authorizes on his behalf, and also a recognition that this too is a community asset for education and welfare betterment.

In recommending that where voluntary hospital facilities are suitable and available, the government makes use of them to the fullest possible extent at proper compensation therefor. The objection that this would be more costly is anticipated. But I am confident that ample evidence could be brought to show that it would in fact be an economy in most communities. The restoration of a patient to health or to useful life, at least, is hastened by efficient hospital care under hospital circumstances properly adapted to his individual circumstances. I believe that nine times out of ten in the average community, rehabilitation of the patient can be made more quickly in the voluntary hospital than in the government hospital, not alone because of the better effect which voluntary hospital care has upon the patient's mental attitude, but because the service is in most cases better.

In my own work in a large metropolitan governmental hospital, I have noted many times how quickly transfer from my own hospital to a voluntary hospital has altered the patient's outlook and prospect of recovery, to his advantage and

the community's. There is real economy in this. If what might normally be a three weeks' recovery and convalescence in a government hospital can be reduced to two weeks by voluntary hospital care, the difference in dollars and cents in favor of voluntary hospital care is worth considering, to say nothing of the gain to the patient and the society in which he lives.

The writer would be the last one to take the position that this thesis offers a complete solution of this problem. In fact, it merely scratches the surface. Any plan which might be devised will require adjustment to the given community, its sickness needs, and financial and other resources. Governmental hospitals of any kind may not be available in the given community; good voluntary hospitals may not be available; financing such a program may be impossible for some communities, and other resources may be lacking; political and other racial, social, religious factors may intervene to divide the community interest. But these difficulties can be overcome by any community sincerely concerned in working out a system of hospital service which will satisfy both the necessities of government, the need of voluntary hospitals for security and advancement, the need of the individual patient, and the welfare of the whole people. We urge consideration of the problem now in every community facing it, and particularly by all those who believe that social power is a more constructive factor in American life than governmental or state power. The two are not synonymous, in spite of the fact that there is now an obvious tendency on the part of unthinking people to believe that governmental power alone can properly represent the common social purpose of our democracy.

Reverend Thomas A. Hyde

The Reverend Thomas A. Hyde, superintendent of Christ Hospital, Jersey City, New Jersey, since 1918, died suddenly on February 7,—age fifty-six.

Born in Brookdale, a section of Bloomfield, N. J., Mr. Hyde was graduated from the General Theological Seminary in New York in 1905. Admitted to the Newark diocese in 1906, he served as curate of St. Paul's Protestant Episcopal Church in Paterson from 1906 to 1909 and then became rector of St. Mary's Protestant Episcopal Church in Jersey City. He was serving as rector when he was appointed superintendent of the hospital.

During his rectorship at St. Mary's he was a member of the hospital council. The year Mr. Hyde took over the management of the institution, the annual budget was $108,000, and the hospital had beds for 100 patients. Two small houses across the street from the hospital housed the nurses' home and there was no superintendent's home.

Today the hospital has 206 beds, with emergency accommodations for nineteen additional patients, a modern home for 101 nurses, an x-ray laboratory and a superintendent's home.

Laura E. Coleman

Laura E. Coleman, superintendent of the Milton Hospital, Milton, Massachusetts, for the past fifteen years, died on January 19, of pneumonia.

Miss Coleman was graduated from the Boston City Hospital's Training School in 1900, and two years later became the first superintendent of Faulkner Hospital, Boston. In 1912 she was appointed superintendent of the Millard Fillmore Hospital, Buffalo, New York, then known as the Buffalo Homeopathic Hospital. She resigned that position to take charge of the nursing service of a base hospital in France during the World War.

Miss Coleman has been a prominent and an active member of the Association since 1905. She was one of the best known hospital administrators in the East. She has served on many important committees and in many prominent positions in the Association during the past thirty-two years.

Hospitals Are Reopening Their Schools of Nursing

During the depression, when there was a definite over-supply of nurses, many prominent hospitals closed their schools of nursing. More recently there are evidences in many parts of the country that instead of an over-supply there is, and probably will continue to be, a definite shortage of competent, qualified graduate nurses. For this reason some of the more important hospitals in our metropolitan centers, including such institutions as the Harper Hospital in Detroit and the Women and Children's Hospital in Chicago, are re-opening their schools of nursing.

The Women and Children's Hospital established the first nursing school in Chicago in 1873. It closed its school in the spring of 1931 because the number of nurses was growing more rapidly than the existing need for their services. The Board of Trustees of this institution decided last fall that the over-supply of nurses had been absorbed, and that there was a potential danger of a shortage of nurses, and for this reason decided to re-open their school of nursing.

Hospital Conference Week in Chicago

DURING the week from February 13 to February 18, one hundred fifty or more hospital administrators met in Chicgo. They were the members of the Board of Trustees of the American Hospital Association, the presidents, secretaries, and chairmen of legislative committees of State and Provincial Hospital Associations, members of the Out-Patient Committee, the Committee on Membership Structure and Association Relations of the American Hospital Association, the Council on Administrative Practice of the Association, as well as managers of hospital service plans and the board of directors of the American College of Hospital Administrators.

Immediately following the meeting of the American Hospital Association groups, the Association of Methodist Hospitals and Homes met in Chicago from February 16 to 19.

The conferences of the various committees and councils occupied each day, and several evening sessions were held. The social feature of the week was the dinner on Monday evening, February 15, given to the officers of the various state and regional associations by the Board of Trustees of the American Hospital Association.

The activities of the various groups will be detailed in the accompanying article and distributed through printed bulletins to the entire hospital field.

Meeting of the Board of Trustees of the American Hospital Association

The meeting of the Board of Trustees of the American Hospital Association was held at Association Headquarters, 18-20 East Division Street, Chicago, Illinois, February 13.

There were present: Dr. C. W. Munger, president; Robert E. Neff, president-elect; Asa S. Bacon, treasurer; Miss Margaret A. Rogers, Miss E. Muriel Anscombe, Dr. N. W. Faxon, Dr. G. Harvey Agnew, Dr. B. W. Black, Dr. Walter E. List, John N. Hatfield, and Dr. W. S. Rankin. Monsignor Maurice F. Griffin was absent due to his participation in the Eucharistic Congress being held in Manila, Philippine Islands.

The meeting was called to order by President Munger, and the Minutes of the meetings of the Board of Trustees held in Cleveland were approved with corrections suggested by Dr. Faxon.

IT WAS VOTED that the budget for the year 1937, as approved by mail ballot, be formally approved by the Board of Trustees.

IT WAS VOTED that the honoraria to certain clerical employees of the American Hospital Association, approved by mail ballot, be formally approved by the Board of Trustees.

The Executive Secretary presented the statement of the Association finances as of February 12, and explained that the deposit for the interest for the next interest period of July 1, 1937, had been made, and that the sums appropriated under the budget for the amortization of the General Mortgage Bonds and the First Mortgage Bonds for the year 1937 had been deposited.

The President next presented for the consideration of the Board the matter of ill-advised articles which have recently been published in the daily newspapers and in magazines, more particularly concerning the care of maternity patients in the home.

There was an extended discussion of this subject, participated in by all members of the Board, after which it was

VOTED that the Board of Trustees call the attention of the various state and provincial associations to the desirability of securing general favorable publicity in the press, sponsored by their associations, and following the lines recommended by the American Hospital Association Committee on Public Education; that the stories emanating from local hospitals be legitimate; and that it be further recommended that the state and provincial associations take up with their hospitals the type of publicity which should be given and that the state associations then recommend that this type of publicity be adopted by the Committee on Public Education.

The Board then discussed the advisability of sending to the International Hospital Congress to be held in Paris in July, 1937, two official delegates of the Association, to present personally the invitation of the American Hospital Association to the Congress to hold its 1939 meeting in North America.

IT WAS VOTED that the President of the Association, Dr. C. W. Munger, and Trustee Dr. G. Harvey Agnew be officially delegated to attend the International Hospital Congress and to present officially the invitation of the American Hospital Association.

IT WAS FURTHER VOTED that the President be authorized to designate as delegates other members of the hospital association, up to ten in

number, as the official delegates of the Association. It was understood that the appointment of these delegates would carry no obligation on the part of the American Hospital Association to bear any expense of their attendance at the International Congress.

The President next presented a communication from the president of the National League of Nursing Education, advising the American Hospital Association that the League of Nursing Education desired to make a cost study of nursing education, at an estimated cost of $9,000, and requesting an appropriation from the American Hospital Association to assist in this work.

After discussion, it was

VOTED to advise the National League of Nursing Education that, due to the present state of the finances of the American Hospital Association, it would be impossible to make a grant of $1,000 for the purpose requested.

The President next presented a communication from the National League of Nursing Education requesting that the American Hospital Association appoint a consultant to the Committee on Accreditation of Nursing Training Schools of the League.

After discussion, it was the sense of the Board that there should be two consultants instead of one to this Committee, and that the committee of the League should be so advised. After an extended discussion, it was

VOTED that the President appoint two representatives of the American Hospital Association to act as consultants to the Committee.

The President next presented correspondence with the Elsie De Wolfe organization, in connection with the American Hospital Association's sponsoring the Coronation Balls which would be held in some twenty cities throughout the United States on May 12. The purpose of the sponsorship by the American Hospital Association was that the Association would assume responsibility for the distribution of any funds raised through the Coronation Balls to the hospitals in the various cities mentioned.

It was also suggested in the correspondence that a small percentage of the net earnings from the Coronation Balls be assigned to the American Hospital Association for medical research purposes.

After an extended discussion, and in view of the fact that it has been the established policy of the American Hospital Association that National Hospital Day—May 12—would not be used for the solicitation of funds in any way by the hospitals, that the correspondence be tabled and the Elsie DeWolfe organization advised that the Association regretted it could not participate in the plan.

The President presented to the Board a discussion of the Robinson-Patman Act, together with a request from a New York group that the American Hospital Association support a proposed amendment to exempt hospitals from the provisions of this Act. After discussion it was

VOTED that the following resolution be adopted:

WHEREAS, during recent years there has been a great decrease in the number and amount of gifts and bequests to the semi-public charitable hospitals of this country and likewise a heavy diminution in the income from securities making up their endowments as well as a considerable shrinkage in the principal value of the endowments themselves, and

WHEREAS, these hospitals now find themselves engaged in a losing battle to keep their doors open and to prevent the curtailment of their services so necessary in these times to uphold the public morals, and

WHEREAS, it is not believed to have been the intention of the Congress that these institutions, supported in whole or in part by public subscription and not operated for profit, should come under the provisions of the Robinson-Patman Act,

BE IT RESOLVED, that the American Hospital Association, a nation-wide agency representing these semi-public charitable voluntary hospitals, as well as public, state, and municipal ones, and speaking for approximately seven thousand hospitals in the United States, hereby places itself on record as being in favor of the exemption of such institutions and their suppliers from the provisions of said Act; and its officers are hereby instructed to petition the Congress for an amendment to said Act expressly providing for such exemption.

The Executive Secretary next presented the order of the Department of Buildings of the City of Chicago to construct a fire escape on the Association's premises at 18 East Division Street, at an approximate cost of $366.

IT WAS VOTED that the Executive Secretary be instructed to arrange for the construction of this fire escape, and that the sum of $366 more or less be appropriated to cover the cost of this construction.

Mr. Hatfield next presented to the Board of Trustees the question of printing, by the Association,

a "Manual of Standards" of hospital supplies. The Committee on Simplification and Standardization of Hospital Equipment and Supplies, of which Mr. Hatfield is a member, had gone to a great deal of trouble in preparing material for the proposed manual. It was estimated that the material already assembled would make a printed volume of some 350 pages.

There was an extended discussion as to the cost involved, the advisability of printing the manual, and its value to the hospital field. After this discussion, it was

VOTED that the expression of the Board of Trustees be conveyed to the Simplification and Standardization Committee that the Trustees believe this material is particularly worthwhile and should be published in book form, and that the Board will accept the report and publish the manual when and as funds for this purpose are available.

At two o'clock, p. m., the Joint Committee, consisting of the Committee on Membership Structure and Association Relations and the Committee on Constitution and Rules, met with the Board of Trustees and explained the progress of their work up to the present time, together with such policies on which the Joint Committee had reached an agreement in connection with the report of the Committee to be presented at the Atlantic City Convention.

IT WAS VOTED that the Board of Trustees express its appreciation for the work accomplished by the Committee, and that the Committee be continued and the changes in the Constitution and By-Laws, as incorporated in the principles outlined, should be presented in a report to the Atlantic City Convention.

IT WAS VOTED that the Committee be requested to prepare a further report to be submitted, if possible, at a June meeting of the Board of Trustees.

IT WAS VOTED that if the Executive Secretary feels there is sufficient space in the Association building to accommodate the offices of the American College of Hospital Administrators, that he enter into negotiations with the College with a view to providing them with accommodations.

IT WAS VOTED that the appointment of Mrs. Mary Hicks Bachmeyer as official secretary of the Council on Community Relations and Administrative Practice be approved.

The Executive Secretary next presented the ruling of the deputy commissioner of the Bureau of Internal Revenue, to the effect that the American Hospital Association was not exempted from the provisions of the Social Security Act so far as the sections relating to old-age and employment provisions were concerned.

IT WAS VOTED that the Executive Secretary pursue the matter further in securing exemption for the American Hospital Association; but the Board expressed its desire that in the event of such an exemption the American Hospital Association should make some provision for the retirement of its employees.

There being no further business to come before the Association, the Board of Trustees adjourned to meet at the call of the President.

Chicago Conference of Presidents, Secretaries, and Legislative Committee Chairmen of State, Provincial, and Regional Hospital Associations

THE mid-year conference of hospital association officers opened at the Palmer House, Chicago, with a secretaries' luncheon on Monday, February 15. The annual conference followed luncheon, with consideration being given first to the observation of National Hospital Day. Albert G. Hahn, chairman of the National Hospital Day Committee, outlined the service that his office was prepared to give in assisting the local hospitals to plan their activities for the Day, and requested the cooperation of the secretaries in having state chairmen appointed at once. Under Mr. Hahn's direction a comprehensive list of appropriate activities has been developed, so that no hospital should have any difficulty in planning as extensive a program as it may desire.

The secretaries whose associations have conventions before May 12, agreed to exhibit in a prominent place National Hospital Day material that will be sent to them for display purposes.

The subject of a state program of Public Education was given the fullest consideration. As an example of the necessity for presenting more clearly the work and needs of the hospital, it was noted that practically every governor of the forty-three states whose legislatures are now in session, presented most prominently in his annual message the need for consideration of the growing number of traffic accidents. They suggested state police, liability insurance, drivers' licenses, speed limitation, and similar measures, but not one of them gave any consideration whatsoever to the care of the traffic accident victim.

Pennsylvania, with a publicity director as assistant to the executive secretary of the state

association, is continuing its regular release of hospital facts to the newspapers of the State. These are being printed by the newspapers of the State, and excellent results are being obtained both editorially and in the growing appreciation of the public for the service of the hospitals. Minnesota has started a newspaper release service, as has the provincial association of Ottawa. The latter is having articles prepared by administrators, which then are edited by a newspaper man so that they may be presented in a newsy manner, before being released to all newspapers in the Province.

Certain secretaries reported that the bulletins of their associations are sent to all newspapers in the state, and the newspapers comment editorially on the material contained in the bulletins, and it has been noted that the attitude of the newspapers has become more favorable to hospitals.

The need for a more active public education policy was appreciated by all of the secretaries present, and there was every promise of increased activity toward public education in the future.

The rehabilitation program adopted by the state of West Virginia—through the efforts of the state hospital association—was described by the executive secretary, James W. Harris, Jr. A survey showed approximately 6,000 men on relief because of disabilities that were amenable to correction. In a test series of 100 cases, 92 men were returned to gainful employment after the correction of their disability, and they and their families taken from relief. As a result, the state legislature passed a public welfare and rehabilitation act, granting state aid to hospitals for the needy and for rehabilitation. The latter presents a wide field for cooperation between the state and the hospitals.

Studies being conducted by the state associations were discussed, with the object in view of correlating such studies and of using a uniform basis of procedure so that the results obtained would have more than a local significance. This is to be given further consideration by the secretaries at the Atlantic City meeting.

The increasing number of labor disturbances and the trend toward shorter hours with an increase of wage scale, and the probable effect of the three upon hospitals, was given much consideration. It was the expressed opinion of the group that every effort should be made to have the rate structure and financing of hospitals placed on a sound basis, so that proper working conditions would be extended to hospital employees.

The secretaries' conference then adjourned to meet for lunch Monday, September 13, at the Atlantic City Convention.

On Monday evening, February 15, the Trustees of the American Hospital Association entertained the presidents, secretaries, and legislative committee chairmen in attendance at the conference, at dinner at the Palmer House. Dr. Claude W. Munger, president of the Association, presided. The program was informal.

The general conference opened Tuesday morning, February 16, with a report of the activities of the Joint Committee, by A. E. Hardgrove.

Dr. A. C. Bachmeyer, chairman of the Joint Committee on Membership Structure, Financing, and Association Relations, then gave a progress report of the Committee. He outlined the tentative principles of memberships, dues, and relationship of associations. The suggestions of the Committee were discussed and on the whole met with favorable reception. The Committee was requested to give attention to the financing of state associations in planning the membership dues.

On motion, it was requested that the tentative principles of reorganization proposed by the Committee be sent to each state and provincial association for presentation at their annual conventions preceding the Atlantic City Convention. The Committee offered to appear at as many state and provincial conventions as possible in order to fully explain the recommendations proposed. It is planned to have these drafted in final form for publishing in *HOSPITALS*, prior to the Atlantic City Convention.

In accordance with action taken at the legislative conference at the Cleveland Convention, George D. Sheats, chairman of the Legislative Reference Committee, presented the draft of a model bill to provide from state funds hospitalization to the recipients of old age pensions for acute conditions. The bill was read and explained in detail. Copies will be sent to the states not represented. Two states—West Virginia and New York—reported that they were covered and would need no further legislation. Ohio and Arkansas reported that their bills have already been presented; in fact the Arkansas bill has been passed and is now before the Governor for approval. Representatives of ten other states signified their intention of preparing bills on the basis of the model bill and introducing them at once. This is the first cooperaive effort on the part of the state associations to adopt a common legislative program, and the hope was expressed that this practice would be continued and that another

common effort be chosen at the Atlantic City Convention for 1938.

Social Security legislation was next considered. The joint Committee reported that they were favorably considering a proposal made by the representatives of another group of charitable institutions, whereby the employees of charitable and educational institutions—now exempted from the old age retirement act—would be permitted to pay their portion of the tax and thereby receive its benefits; but to continue the exemption from taxation of the institutions themselves. This is in accordance with other forms of taxation, such as income, personal property, real estate, and other taxes. The employees have never been exempted from any forms of taxation, from which the institutions have been exempted—both receiving all the benefits of such taxation. Accordingly, if precedent were to be followed, under the Social Security Act the type of amendment proposed would be most logical.

This proposal met with the unanimous approval of those present, and the Joint Committee was assured of the support of those present in seeking such an amendment. Those present expressed the opinion that in case this effort was unsuccessful, further effort should be made to receive the benefits of the old age retirement act for the employees, but they were divided as to whether it should be compulsory upon all institutions or whether an amendment should be sought whereby the institutions be given the power of electing to come under the act or not.

No desire whatsoever was expressed for the inclusion of hospitals under the unemployment compensation act; so no effort will be made regarding this section of the Social Security Act.

The Robinson-Patman Act, passed last year by Congress, to regulate trade practices, was next discussed. It had been the expression of opinion by those consulted by the Joint Committee that the Act did not include hospitals. However, members reported that dealers, either through fear of the Act or by taking advantage of it as an excuse, were raising prices to hospitals. The need was expressed, therefore, that the right of exemption of hospitals under the Act be fully determined.

The extension of veterans hospitals was presented. Information received from the Veterans Administration was that need for beds for tubercular patients was decreasing, the occupancy of acute beds was leveling off and would probably remain about stationary until 1948 or 1950, while the need for neuro-psychiatric beds was increasing. From this, only additional facilities for neuro-psychiatric patients are required, and there should be no further increase in veterans hospitals for general conditions. The demand for the latter usually arises from local sources. Either interested groups in a congressional district secure the cooperation of their congressmen in introducing a bill for a new hospital, or, in a number of instances, the state legislature has memorialized Congress to build a new hospital in their state. Accordingly, the cooperation of the state associations was requested in trying to stop these demands before they reached Congress, for apparently there is no need for further general hospital beds for veterans.

The meeting ended with a round table discussion of state and provincial legislation. Lien laws, licensing of hospitals, legislative policies, and methods of reimbursement were all considered. Several states reported that they had prepared licensing acts, but upon reconsideration had not presented them.

Lien laws were being introduced in a number of states and it was reported in some cases that passage was not secured until an exemption of small settlements, such as $100, was included in the bill, so as to permit nuisance settlements. The general discussion of state and provincial legislation concluded the meeting.

Conference of Hospital Service Plan Executives

A conference of Hospital Service Plan Executives was held in Chicago February 15, at the Palmer House. This meeting, which was called by Dr. C. Rufus Rorem, Director of the Committee on Hospital Service, was for the purpose of discussing the administrative and social problems of voluntary hospital insurance and of forming a Group Hospitalization Section of the American Hospital Association. Officers of the newly formed Section are Bryce L. Twitty of Dallas, Texas, chairman and E. A. van Steenwyk of St. Paul, secretary, who will organize a program for the annual convention in Atlantic City.

An advisory committee of service plan executives was appointed to assist in the work of the Committee on Hospital Service. In addition to the chairman and secretary of the Section the members are Perry Addleman of Chicago, Felix Grisette of Chapel Hill, North Carolina, E. J. Henryson of Washington, D. C., John A. McNamara of Cleveland, Frank Van Dyk of New York City.

Non-profit hospital service plans are continuing to grow rapidly, and substantial reserves are being establshed which will ultimately lead to expan-

sion of benefits or reduced annual rates. As of February 10, the New York enrollment had exceeded 250,000 subscribers and dependents for full coverage and more than 750,000 were enrolled in the United States.

The conference approved certain criteria or guiding principles submitted by the Committee on Hospital Service, which were based upon previous standards established by the American Hospital Association. These were as follows: (1) emphasis on Public Welfare; (2) non-profit sponsorship and control, with boards of trustees giving adequate representation to hospitals, medical profession and general public; (3) economic soundness with subscription rates, contracts, working capital and reserves approved by appropriate regulatory bodies; (4) free choice among hospitals of standing in the community; (5) limitation to hospital service, with the benefits determined through agreements with the hospital staffs in the various communities; (6) dignified administration and promotion.

In addition to the executives selected for the advisory committee the following official representatives of service plans were present at the conference: Ellerd Slack, Oakland; R. D. Brisbane, Sacramento; Paul F. Bourscheidt, Peoria, Illinois; D. Lane Tynes, Ashland, Kentucky; Edward Groner, New Orleans; Ray McCarthy, St. Louis; J. D. Colman, Newark, N. J.; W. M. McLeod, Elizabeth, N. J.; E. R. Evans, Albany; Carl M. Metzger, Buffalo; Sherman D. Meech, Rochester; W. W. Seymour, Syracuse; D. E. Deichmann, Durham, N. C.; George W. Eutsler, Kingsport, Tennessee; M. Haskins Coleman, Jr., Richmond, Virginia; John Hart, Charleston, West Virginia; A. R. Hazzard, Easton, Pennsylvania; James R. Mays, Abington, Pennsylvania; William J. Billick, Des Moines; C. C. Huffman, Shreveport, Louisiana.

A summarized report of the conference is available to interested persons from the Committee on Hospital Service of the American Hospital Association.

Coming Meetings

National Methodist Hospitals, Homes and Deaconess Association, Cincinnati, Ohio, February 17-19.

Massachusetts Hospital Association, Boston, February 25

New England Hospital Association, Boston, Massachusetts, February 25-27

Alabama, Florida, and Georgia Hospital Associations, Atlanta, Georgia, April 8-10, 1937

Association of Western Hospitals and the Association of California Hospitals, Los Angeles, April 12-15

Ohio Hospital Association, Columbus, April 13-15

Michigan Hospital Association, Ann Arbor, April 15-16

North Carolina, South Carolina, and Virginia Hospital Associations, Raleigh, April 22-24

Texas Hospital Assn., Lubbock, April 23-24.

Iowa Hospital Assn., Dubuque, April 26-28.

Tri-State Hospital Association (Illinois, Indiana and Wisconsin), Chicago, May 5-7

Mississippi Hospital Association, Meridian, May 10

Minnesota Hospital Association, Rochester, May 13-15

Hospital Association of New York, New York City, May 20-22

New Jersey Hospital Association, Atlantic City, May 27-28

Hospital Association of Pennsylvania, Buck Hill Falls, June 2-4

Mid-West Hospital Association, Colorado Springs, Colorado, June 10-11

Manitoba Hospital Association, Brandon, June 24-25

American College of Hospital Administrators, Atlantic City, September 12-17

American Occupational Therapy Association, Atlantic City, September 13-17

American Protestant Hospital Association, Atlantic City, September 13-17

Children's Hospital Association, Atlantic City, September 13-17

National Association of Nurse Anesthetists, Atlantic City, September 13-17

American Hospital Association, Atlantic City, September 13-17

Hospital Association of Nova Scotia and Prince Edward Island, Sydney, Nova Scotia, July, 1937

Ontario Hospital Association, Toronto, Oct. 25-27

Kansas Hospital Association, Newton, October 30

Questions and Answers

Question: What constitutes a free patient and what constitutes a part-pay patient?

Answer: The American Hospital Association has generally accepted the definition of a free patient as a patient who is admitted and cared for in the hospital, and from whom no remuneration is expected or received; in other words, one who is a charity patient and for whose care the hospital receives no reimbursement from private, public, or philanthropic sources. His care and service is the charity bounty of the hospital.

A part-pay patient is any patient admitted to the hospital who pays for his hospital service and the care rendered, but who does not pay the full cost of the service rendered. The patient may be admitted to the ward at a rate, say of $3.25 a day, but the actual cost of maintaining a patient in the ward under the same conditions and in the same environment as the patient referred to costs the hospital $4.25 a day. Then, in the accepted and a logical definition of a part-pay patient, this patient would come within that category.

However, it is frequently interpreted to mean, "paying as much as he could afford to pay of the established rate for the accommodations which he enjoyed while a patient in the hospital." For instance, if the regular ward rate were $3.25 a day, and the patient was admitted for $2.00 a day, he would be a part-pay patient under such an interpretation; but the better interpretation would be, "any patient admitted to the hospital would be a part-pay patient who did not pay the full cost of the hospital service received in the ward, room, or semi-private room to which he was assigned."

Question: What is the prevailing trend in salaries for institutional nurses?

Answer: Sharply up. One institution which had an adequate supply of general duty nurses one year ago at $50 with maintenance per month has increased to $65 with maintenance without adequate response, and is now endeavoring to finance an increase to $75. This hospital is in a metropolitan center, has excellent living conditions, and exerts every effort to accommodate those who are taking courses of study in other educational institutions. Some other hospitals in the same city have already made the above increases, and others are contemplating them as the supply is still definitely lagging behind the demand.

Salaries for those in executive positions, particularly in the lower grades, have likewise advanced but not in the same ratio.

In the smaller communities the same trend is noticeable, the present rate being $60 to $65, as a general rule, as compared to $50 or less one year ago. Some sections of the country in which salary scales are usually below the average have been paying $30 to $35 up to one year ago, and are now offering $45 to $50.

Question: To what extent is fever therapy applicable to general hospital use?

Answer: Apparatus for fever therapy is gradually focusing on the heated cabinet for treatment of general systemic disease, and on some of short wave diathermy or induced current therapy for more localized disease conditions.

The heated cabinet is equipped to circulate a current of air of controlled temperature and humidity, and at a definite rate of air change. The apparatus with which most careful clinical study has been done is not yet on the market, but is loaned to selected hospitals. It has shown very good results in all forms of gonorrhea infections, acute or chronic, in neuro syphilis, and in chorea, and may be substituted for any form of nonspecific protein fever therapy. Generally applied to such cases of low grade infectious origin as are marked by low fever or none at all, its results have not been consistent in diseases other than the three mentioned above. Some patients are benefited while others with similar conditions do not respond. The treatment occupies from five to seven hours, during which time the patient must be under continuous, unremitting supervision.

In case the apparatus is used for local treatment, the treatments simply expand the field to which local heat is applicable, require a much shorter time, but must be skilfully selected and supervised if good results are to be expected.

National Hospital Day

ALBERT G. HAHN, Chairman

National Hospital Day Committee, Evansville, Indiana

EARLY EACH YEAR the National Hospital Day Committee begins to encourage all the hospitals throughout the United States and Canada to plan a program for National Hospital Day, May 12. This day gives each hospital the opportunity to make the citizens of their respective communities more hospital minded.

When hospital executives annually put money into a thing, it is proof that it is worthwhile. From the reports received, I am confident that the hospitals are putting money into plans for National Hospital Day. The reports show that many hospitals throughout the United States and Canada purchased educational materials last year. The summary of materials purchased from one company alone is as follows:

Post Cards	49 hospitals
Movie Trailers	12 hospitals
Posters	97 hospitals
Letters	6 hospitals
Pencils	21 hospitals
Newspaper Mats	30 hospitals
Stickers	55 hospitals
Publicity Folders	166 hospitals

National Hospital Day was instituted in 1921, and since 1925 certificates of award have been given to the hospital presenting the most outstanding program on National Hospital Day. The following hospitals have received the award:

1925—Pottstown Hospital, Pottstown, Pennsylvania

1926—U. S. Veterans Hospital, Waukesha, Wisconsin

1927—John D. Archbold Memorial Hospital, Thomasville, Georgia

1928—Bushwick Hospital, Brooklyn, New York

1929—Bergen County Hospital, Bergen Pines, Ridgewood, New Jersey

1930—Richmond Memorial Hospital, Prince Bay, New York

1931—Brantford General Hospital, Brantford, Ontario

1932—Paterson General Hospital, Paterson, New Jersey

1933—Glendale Sanitarium, Glendale, California

1934—Protestant Deaconess Hospital, Evansville, Indiana

1935—Lutheran Hospital, Brooklyn, New York

1936—Group I, Wesley Hospital, Wadena, Minnesota

—Group II, Conemaugh Valley Hospital, Johnstown, Pennsylvania

(Group I—Cities of 15,000 population and under; group II—Cities of over 15,000 population)

The Pennsylvania Hospital Association commended Conemaugh Valley Hospital, of which Mr. H. G. Fritz is superintendent, for winning the award this year for the best National Hospital Day program in the large hospital division and passed the following resolution:

WHEREAS: The American Hospital Association each year at the annual convention, awards a certificate to the hospital in the United States or Canada having the most instructive and best attended program during National Hospital Day, May 12—Florence Nightingale's birthday—and

WHEREAS: The Conemaugh Valley Memorial Hospital of Johnstown was awarded the certificate for the year 1936 at the American Hospital Association Convention in Cleveland, September 28, of this year, be it

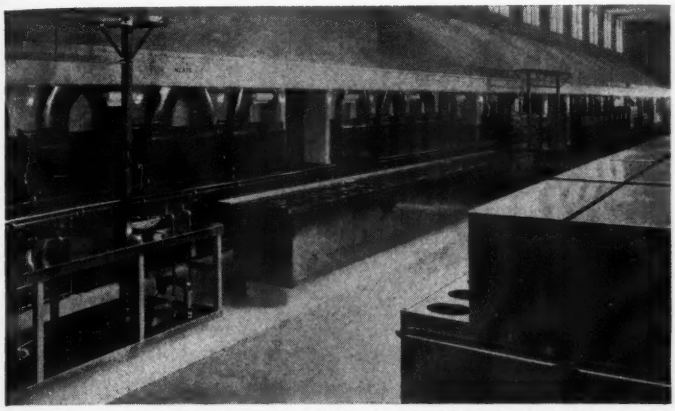
RESOLVED, by the Board of Trustees of the Hospital Association of Pennsylvania that the Conemaugh Valley Memorial Hospital be congratulated for its activity which earned for it the National Hospital Day Award for 1936, and be it

FURTHER RESOLVED, that the Conemaugh Valley Memorial Hospital be especially commended for bringing to a hospital in the State of Pennsylvania national recognition for outstanding work in public relations.

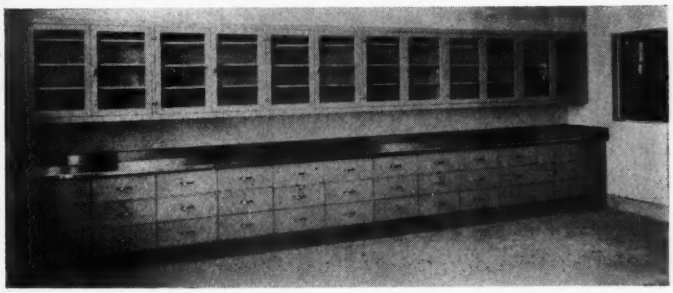
At Wadena, Minnesota, on the evening of November 20, the National Hospital Day Award was presented to Miss Madell Motsiff, as superintendent of the Wesley Hospital, for the finest National Hospital Day program in the small hospital division in the United States and Canada. Sixty-nine guests were gathered to do honor, and a splendid banquet was served. The guests came from sur-

Business Manager and Chief of Staff **AGREE**—

One says, "Keep costs down"
The other says, "Keep sanitary standards up"
Both say, "Buy Equipment of Monel Metal"



Main kitchen in Los Angeles County Hospital, Los Angeles, Calif. Monel Metal food service equipment installed by National Cornice Works of Los Angeles.



YOU'D like to keep your budget in balance, of course. But never at the cost of lowered standards of cleanliness. And you're right. In choosing any equipment from laundry to operating room, you never compromise with absolute sanitation . . . no matter what the cost.

But there's ONE metal widely used in hospitals which satisfies both operating management and chief of staff. You find Monel Metal, among many places, in sterilizers, in hospital kitchens and laundries, and as tops for cases in surgical dressing rooms.

Monel Metal makes it easy to keep perfect sterility. It can not rust. Its solid surface has no coating to crack or chip. It is highly resistant to corrosion from most hospital solutions. Its silvery surface gleams cheerily at you through years of hard service.

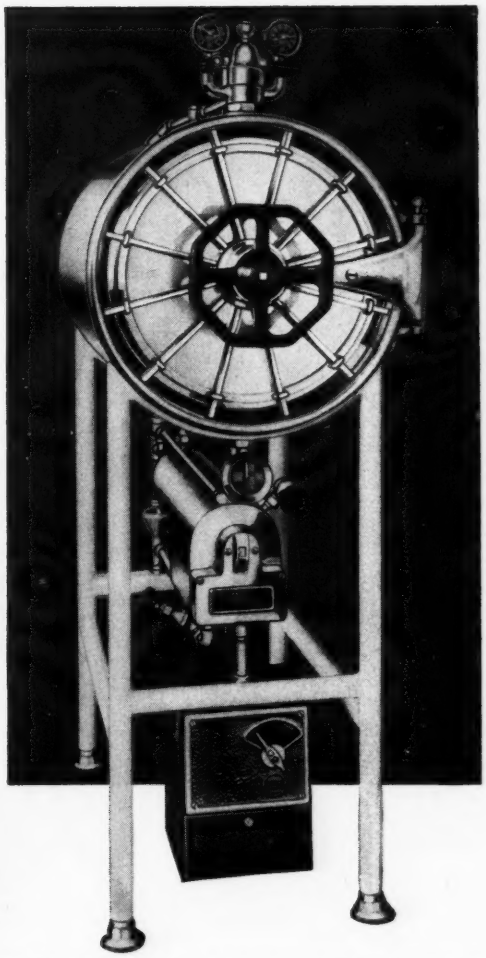
And for these same reasons . . . because Monel Metal can be kept CLEAN with ease for years after other metals have had to be discarded . . . Monel Metal cuts down replacement cost and helps balance the budget.

Monel Metal can be fabricated by all standard methods, to form any of your equipment. Prices will surprise you pleasantly too. Give Inco's engineers the chance to furnish you full information.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 WALL STREET NEW YORK, N. Y.

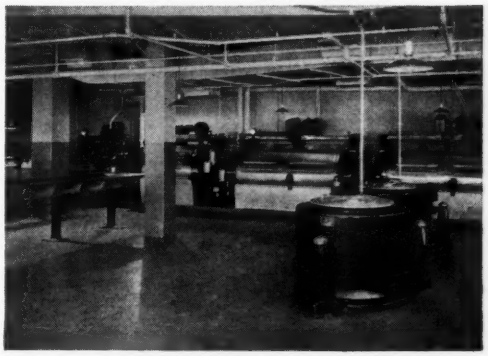
MONEL METAL

Monel Metal is a registered trade-mark applied to an alloy containing approximately two-thirds Nickel and one-third copper. Monel Metal is mined, smelted, refined, rolled and marketed solely by International Nickel.



Sterilizer shells fabricated by American Sterilizer Company of Erie, Pa. Walls of the Sterilizing chamber and the steam jacket are made of Monel Metal as well as outside shell.

(Left) Built-in cases installed by the General Fireproofing Company, Youngstown, Ohio, in the surgical dressing room of the Youngstown City Hospital, Youngstown, Ohio. Monel Metal tops were standard equipment on several hundred of these units.



American Monel Metal Cascade Washers and Extractors in the Doctors Hospital, New York, N. Y., manufactured by the American Laundry Machinery Company, Cincinnati, Ohio.

Send for your copy of
"The Selection of Hospital Equipment"
and
"The Selection of Food Service Equipment."

rounding hospitals and towns. The Minnesota State Association was represented by President A. F. Branton, Vice-President H. A. Burns, Secretary A. M. Calvin and by the Chairman of the Small Hospital Committee, Esther Wolfe. Greetings were extended to Miss Motsiff and her hospital nurses by the staff, the Association officers, and other guests, and as a climax the beautiful parchment scroll was presented as a lasting reminder that Miss Motsiff and her hospital had been outstanding on Hospital Day 1936.

The incident at Wadena definitely shows that giving two awards in 1936 and giving the smaller hospitals an opportunity to win recognition not only stirred up the entire state of Minnesota but confirms the belief that the two certificates should be continued in 1937 as a large percentage of our hospitals are included in the so-called smaller hospital group.

Our legislators are now meeting in Washington. Do they have the hospital outlook for the hospitals in their respective communities? If not, why not? What has been done to educate them? Begin now to educate and make your legislators hospital minded by planning a program for this year that will attract them to visit their local hospitals and study their problems on National Hospital Day.

Now is the time for the hospitals to begin making their plans. Have a talk with your Mayor now, arranging that he make a proclamation on the day. Also, begin now to contact your local broadcasting stations to secure time for special broadcasts on National Hospital day and to secure their consent to use radio pluggers about National Hospital Day during the days just preceding May 12.

May I submit excerpts for proclamations that may be suggestions for your Mayor.

"The observance of May 12 as National Hospital Day in (city), with the aim of directing public attention to the fine humanitarian effort of our hospitals, is deserving of all cooperation and support. This movement, although originating as recently as 1921, has not only spread throughout the United States and Canada, but has been inaugurated in a number of other countries. In selecting the birthday anniversary of Florence Nightingale you are making the occasion, incidentally, a memorial to one of the great women of the nineteenth century. I extend my earnest wishes for the wide observance of the day, and my hope that it may be productive of results calculated to the further advance of the (city) Hospitals."

"The approach of National Hospital Day again summons to mind the many blessings that have been bestowed upon us in the year just passed by the self-sacrificing men and women who conduct the hospital in this city. It is altogether fitting that this observance should fall on the anniversary of the birth of Florence Nightingale, the British war nurse to whom we trace the high standards of the modern nurse and much of the high standards of the modern hospital.

"We are in a new era of healing; the old pest house has gone; it has been replaced by a vast scientific structure whose cost mounts each day as some new advance is made in medical science. Behind the imposing walls of our hospitals is private philanthropy. In honoring our healing institution and the surgeons, physicians and nurses who conduct it we must also honor those broad-visioned men and women in private life who give so much of their worldly possessions to provide those costs which our unfortunates accept as charity. Now, therefore, I, ... Mayor of the City of ....., do hereby designate and set aside Wednesday, the twelfth day of May, 1937 as Hospital Day to be observed by all the people of this city."

"WHEREAS, ... Hospital is one of the most outstanding and deserving of our civic organizations, and

"WHEREAS, Wednesday, May 12, is being observed throughout the United States as National Hospital Day as a time for paying tribute to these institutions for the service they give to the public.

"Therefore do I declare Wednesday, May 12, as Hospital Day in (city) and do most heartily urge all citizens of (city) to show their appreciation to ..... Hospital by visiting it on that day."

Here are some suggestions for your local radio station to use as pluggers:

"Florence Nightingale's work gathers momentum as the years pass on. Born 117 years ago next Wednesday, she raised nursing to a profession and thereby changed the whole atmosphere of the hospital. Hospitals are holding open house next Wednesday, May 12."

"Let us pay a tribute to a great woman—Florence Nightingale, the Crimean War nurse, who made nursing a scientific profession. She was born 117 years ago and we yearly mark the event by celebrating National Hospital Day. When you honor your hospital, you pay a tribute to this great benefactress. Visit your hospital on her birthday, next Wednesday, May 12."

"Usually we don't like to visit hospitals, but next Wednesday, May 12, the hospitals throughout the United States and Canada are holding open house. We are all invited. Incidentally, the Twelfth is Florence Nightingale's birthday and

BAXTER'S ARE THE PIONEER SOLUTIONS

In every page of history, in every conquest of science or geography or medicine there will be found a pioneer.

A pioneer, with imagination to conceive—with determination to do—with ability to execute—with vision to plan.

Baxter is the pioneer in the development of commercial ready-to-use solutions. Baxter developed intravenous solutions to a high point of perfection, then developed the incomparable Vacoliter — Baxter's dispensing container for intravenous solutions.

In recognition of Baxter's pioneering, the hospitals of America have, by their voluntary acceptance of the Baxter ideal, placed and continuously maintained Baxter in a position of pre-eminence in the field of commercial ready-to-use intravenous solutions.

It costs your hospital no more to use Baxter's Intravenous Solutions in Vacoliters. In fact, we can show you how you may use Baxter's, the pioneer solutions, at even less than your usual cost. Write for information about the Baxter plan.

BAXTER'S INTRAVENOUS SOLUTIONS IN VACOLITERS ARE PRODUCED BY BAXTER LABORATORIES IN GLENVIEW, ILL. • GLENDALE, CAL. • COLLEGE POINT, N. Y.

DISTRIBUTED EAST OF THE ROCKIES BY

AMERICAN HOSPITAL SUPPLY CORP. • CHICAGO • NEW YORK

the hospitals are paying tribute to that remarkable woman."

"Attention! Help your local hospital celebrate the one hundred seventeenth birthday of Florence Nightingale. All hospitals will hold open house, Wednesday, May 12, and will be delighted to welcome old friends and new."

"And here is an interesting event coming! The hospitals are celebrating the one hundred seventeenth anniversary of the birth of Florence Nightingale on Wednesday, May 12. You will be welcome at your community hospital."

Any local retailer can assure you that national advertising directly benefits his business. It is self evident that when you plan an observance on National Hospital Day in your local institution that the national broadcasting and the articles appearing in the leading national publications will directly benefit your hospital. The two must be definitely linked together; so, therefore begin immediately making your local plans.

Each state is expected to appoint a special committee to conduct the plans for National Hospital Day in their respective state; and your National Hospital Day Committee is prepared to cooperate with the state committees in every way. The members of your national committee are as follows:

Albert G. Hahn, Chairman, Protestant Deaconess Hospital, Evansville, Indiana

Mrs. Lola M. Armstrong, R. N., 1220 North State Street, Chicago, Illinois

Carolyn E. Davis, R. N., 2068 Interlaken Place, Seattle, Washington

Graham L. Davis, The Duke Endowment, Charlotte, North Carolina

Lawrence Crowley, Hospital Management, Chicago, Illinois

Rev. Edward F. Garesche, S. J., Catholic Medical Mission Board, New York, New York

George Greene, Hospital Forum, Portland, Oregon

Mrs. Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Indiana

Robert Jolly, Memorial Hospital, Houston, Texas

M. Ray Kneifl, Catholic Hospital Association, St. Louis, Missouri

Margaret E. Kennedy, Sanatorium of Paris, Paris, Texas

Malcolm T. MacEachern, M. D., American College of Surgeons, Chicago, Illinois

Veronica Miller, R. N., Henrotin Hospital, Chicago, Illinois

A. J. MacMaster, R. N., Moncton Hospital, Moncton, N. B., Canada

Joseph A. Morrow, M. D., Bergen County Hospital, Ridgewood, New Jersey

Alden B. Mills, The Modern Hospital, Chicago, Illinois

G. W. Olson, Queen's Hospital, Honolulu, Hawaii

Mrs. Meta Pennock Newman, The Trained Nurse and Hospital Review, New York, New York

Harold T. Prentzel, Friends Hospital, Philadelphia, Pennsylvania

Mary M. Roberts, R. N., American Journal of Nursing, New York, New York

Homer F. Sanger, American Medical Association, Chicago, Illinois

Leonard Shaw, Saskatoon City Hospital, Saskatoon, Sask., Canada

Sister DeLellis, R. N., St. Elizabeth's Hospital, Youngstown, Ohio

Sister Mary Immaculata, R. N., Lelia Y. Post Montgomery Hospital, Battle Creek, Michigan

Rev. Clinton F. Smith, Grant Hospital, Chicago, Illinois

Bryce L. Twitty, Baylor Hospital, Dallas, Texas

Katherine Moyer, Lake Wales Hospital, Lake Wales, Florida

H. G. Fritz, Conemaugh Valley Memorial Hospital, Johnstown, Pennsylvania

Clarence C. Hess, Methodist Hospital, Indianapolis, Indiana

Mrs. Jessie D. Scott, Children's Hospital of East Bay, Oakland, California

A Pioneer English Nurse

Mrs. Elisabeth Mary Corbett, one of England's pioneer nurses, and her husband recently celebrated their golden wedding anniversary.

Mrs. Corbett was one of the first probationers to join the Florence Nightingale Nursing School and saw Dr. Sidney Jones perform the first operation in which antiseptic surgery was used in England.

She was associated with Mrs. Garrett Anderson and Dame Jane Walker in the earliest days of the new Hospital for Women, Maryleboneroad, London.

M. BURNEICE LARSON,
DIRECTOR

. . . . to tug at the traces . . . . to drink deep of life years and years before you are old

They tell that all the things we long to do, all the things we long to have, and all the things we long to be, come surest to those of us who tug at the traces.

Then why not tug?

Why not find the job that'd *make* you tug? Why not find the job that'd give you shiny eyes, a set and pointed chin, a *lilt* to your voice, a toss to your head?

Don't turn away. Honest, we're talking to you. It makes *no* difference who you are nor what your work, if you aren't tugging at your traces you aren't doing your work as it can be done.

If you aren't doing it as it can be done you are in a rut or you soon will be; you are doing work that should be done by someone who'd *love* it, *live* it, *lick* it . . . and *somewhere* there's a job like that for you.

Find it. Be courageous. Live *all* of your life; don't depend upon tomorrow. Do *now* the things that thrill, the things you'd *love* to do. Get the job that'd call *all* of your energies, all of your enthusiasm and fight, and *be* the person you dream you'll be.

We will help. Ask us. Tell us all about yourself, what you are, what you'd like to be. *That* is our great business: to find the job for you you'd love; to find for hospitals the *finest* people, the *smartest* in the land.

The MEDICAL BUREAU

55 E. Washington Street
The top floor of the tower of the Pittsfield Building
CHICAGO, ILLINOIS

Contemporary Hospital Thought

The future presents a number of problems significant to hospitals and the medical profession. The increasing complexity of good medical care, with the attendant cost, presents a difficulty to the man of moderate means which must be overcome. The answer seems to lie along the lines of voluntary group hospital insurance, conducted by a community agency on a non-profit basis. Such plans are already in effect in a number of localities and are working to the satisfaction of all concerned when properly organized. The experience is now great enough to be beyond the experimental stage.

This should also help to solve another great problem, namely, the prevention of the abuse of medical charity by a relatively small but significant number of people. Funds furnished by private benevolence and by grants from the public treasury should be guarded for the use of those who need them.

Willmar M. Allen, M.D.,
Medical Director, Hartford Hospital.

To the care of the patient whose medical need may be aggravated by social factors the medical social worker in the hospital has an important contribution to make. Her close relationship to the physician, the hospital administration and the community makes it possible for her not only to have an opportunity to study the individual's medical social needs, in close collaboration with the doctor, but places her in a position to help the patient work out solutions to his problems. Medical social case treatment is the "interpretation of the medical social situation for the purpose of increasing the effectiveness of the patient's participation in his medical treatment and adjustment to his illness."

Experience has demonstrated the importance of keeping abreast of the changes and developments in social and health work, and there is a constant attempt to have a more comprehensive understanding of the social worker's part in the medical team work which is vital to the care of the patient. The problems referred to the social worker may range from a simple short time contact to a full and comprehensive treatment of the whole social problem.

Laura B. Biggs,
Director, Medical Social Service,
Hartford Hospital.

With the rapid advances being made in Medical Service comes a corresponding increase in the cost of hospitalization, due to the fact that modern medicine requires an expensive equipment, more scientific treatment and more bedside care. To the well-to-do this increased cost makes almost no difference, neither does it affect the patient of little or no means, as he is taken care of through our free bed account; and in specific cases we make a reduced ward rate, which is made possible by our income from endowments. Between the well-to-do and the deserving needy there is that great percentage of middle class patients who make every effort to pay the cost of care but find it a heavy burden. It is with this class in mind that we are endeavoring to arrive at a plan which will meet the needs of these patients. We sincerely hope in the near future that this may be accomplished.

L. A. Sexton, M.D.

The present work and the future of the voluntary hospitals are matters of great concern to us, as doctors. The demands of our times, with the lack of facilities and accommodations for home treatments, the plans for increased social security, the increasing requirements for refinements in accommodations and hospital luxuries, and the service that may be required in the future for all those now becoming pensioners of the government through social security programs, have been making and will make still further radical changes in hospital service.

The original purpose of restoring the sick poor to health with the greatest speed is over-shadowed partially or completely at times by the subject of scientific research, and despite endowments, bequests and gifts, seemingly only those entirely-free patients are admitted who contribute to that end. Nurses being trained at great cost to specially high educational standards, very large staffs or attending doctors, many clerical and technical assistants, resident physicians and interns in necessarily great numbers, the administration organization with its members, those highly expensive instruments of precision housed in laboratory quarters or buildings of their own, and the standardizing requirements of outside groups have compelled the voluntary hospitals to reduce their service to the indigent sick and to charge people, who could pay an ordinary fee, rates that become heavily burdensome. Competing hospitals, strictly private, organized for

» » EXERCISE « «

Exercise is one of the important factors in the treatment of constipation. Of equal importance are suitable diet and a regular habit time for bowel movement. Unfortunately, under the present mode of living, such strict regimen is difficult to enforce. While your patient may be inclined to forsake suitable diet and exercise, it is imperative that a daily bowel movement be maintained. Petrolagar assists in establishing a normal bowel movement as it mixes intimately with the feces to form a soft easily passed stool. . . . By the use of Petrolagar habit time may be readily established and maintained.

Petrolagar is a mechanical emulsion of pure liquid petrolatum (65% by volume) and agar-agar. Accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the treatment of constipation.

Petrolagar

profit, free of many of these burdens, and caring only for those able to pay, despite the special costs of taxation and in many instances less efficient and less critically scrutinized work, have been growing in numbers and supplying many needs.

We know the great aid that has been rendered these voluntary hospitals by their lay trustees. Men and women of noblest intentions and benevolent hearts have given of their trained business minds, of their time and their money and their long-continued unselfish attention to the support and welfare of these institutions. Their burdens have been made more onerous of late by the reduction in number and amounts of gifts necessarily following our depressed times and increased taxation.

Thomas A. McGoldrick, M. D.

Great hospitals with their schools are something more than blocks of buildings where patients are doctored, and students and nurses taught. I do believe in the spirit of the place.

Stephan Paget.

"Whether we will it or not, statistics we shall always have with us, and certainly hospital statistics for they are not likely to go out of fashion for some time to come. There may be hospital managers among you who believe, perhaps, that we are paying too much attention to statistics and records, and that greater efforts should be directed to giving 'service' to patients and 'humanizing' our hospitals.

"I would not for one moment suggest that statistics and records should stand in the way of giving undivided attention to the care of the patient, who must be our first concern. I would rather urge that statistics and records be used as the broad foundation upon which intelligent and sympathetic care is based and which will indicate to the hospital administrator to what extent the hospital really serves the individual patient and the community."

Emil Frankel, Director,

Division of Statistics and Research, New Jersey Department of Institutions and Agencies, Trenton, New Jersey

---

This is a community hospital. The trustees propose to operate it to the full extent of its ability to serve, and rely upon the people to co-operate in solving financial problems as imperative needs arise.

The value and necessity of this public co-operation is evidenced by the Infantile Paralysis Fund. Last year some 50 children were afflicted. Such epidemics may be expected periodically. The fund contributed to the cost of a technician, hospital care when required, and splints and braces. By the prompt and efficient treatment thus provided many of these children, averaging about eight years old, have been cured, others are still being treated. None of them will be helpless. It cost a lot of money which we could not afford to spend. Your investment in the fund was repaid many times over.

This hospital belongs to the public. The trustees are its agent. They are confident that the people will co-operate to enable it to continue in efficient service.

Annual Report, Twin Hospital,
Fall River, Massachusetts.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF MARCH 3, 1933,

Of "HOSPITALS," published monthly at Chicago, Illinois, for October, 1936.

State of Illinois, County of Cook—ss.

Before me, a Notary Pubic in and for the State and county aforesaid, personally appeared Bert W. Caldwell, M. D., who, having been duly sworn according to law, deposes and says that he is the Editor and Exec. Secy. of "HOSPITALS," and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher—American Hospital Association, 18 East Division St., Chicago.

Editor—Bert W. Caldwell, M. D., 18 East Division St., Chicago.

Managing Editor—Bert W. Caldwell, M. D., 18 East Division St., Chicago.

Business Manager—Bert W. Caldwell, M. D., 18 East Division St., Chicago.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.)

American Hospital Association, Inc., 18 E. Division St., Chicago, Illinois.

C. W. Munger, M. D., President, Grasslands Hosp., Valhalla, N. Y.

Asa S. Bacon, Treasurer, Presbyterian Hosp., Chicago, Illinois.

Bert W. Caldwell, M. D., Exec. Sec., 18 East Division St., Chicago, Illinois.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.)

None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

BERT W. CALDWELL,
Editor and Exec. Secy.

Sworn to and subscribed before me this 28th day of October, 1936.

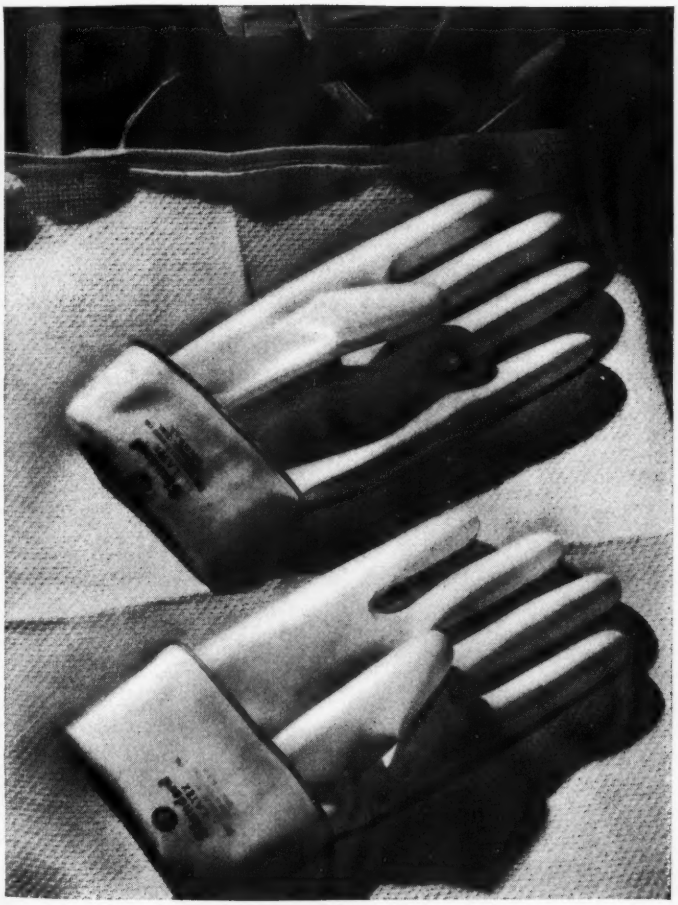
(Seal)

E. WELLS,
(My commission expires March 1st, 1938.)

This trade mark identifies all hospital products manufactured by The Seamless Rubber Co. Look for it—it is a mark of quality.

MARK OF QUALITY · THE SEAMLESS RUBBER CO. INC. · SR

ROUND-TRIP TICKET



The Seamless trademark on a pair of Latex Surgeons' Gloves is an assurance of satisfaction—to your surgeons and to you. Again and again these fine gloves come back from their rigorous round-trip to the autoclave as elastic and strong as new. By test they far outlast ordinary gloves. They're easy on your budget. Yet they are so beautifully made of gossamer-thin rubber that your most critical staff member will approve them. Order Seamless Standard Surgeons' Gloves from your Hospital Supply House—either Brown-milled or Latex.

In addition to Seamless Standard Surgeons' Gloves, your Hospital Supply House maintains complete stocks of a wide variety of other Seamless rubber products for hospital use. The Seamless Rubber Co., Inc., New Haven, Conn.

seamless

Standard Latex SURGEONS' GLOVES

Legal Decisions of Interest to Hospitals

THIS is the eighth of a series of notes upon court decisions in the several states, which affect hospitals or where the hospital was a party to the litigation.

Kentucky

Liability of Public Institution for Assault Upon an Inmate.

Williamson v. Louisville Industrial Reform School, 95 Ky. 251, 24 S. W. 1065

The petitioner, Williamson, sued by his next friend for an assault committed upon him by one of the employees of the school. A demurrer was filed by the defendant to test the sufficiency in law of the complaint, and the lower court dismissed the petition of the plaintiff. The Court of Appeals upheld the action of the lower court.

It appeared that defendant had been incorporated in 1854 under the name of the Louisville House of Refuge, for the purpose of caring for youths who had been committed to it. The purposes of the defendant were essentially of a charitable nature. Further, it was shown that the defendant was an agency of the state, being maintained by state taxation.

The court, in denying the right of plaintiff to recover, held that the defendant was (1) a charitable organization, (2) that the funds appropriated for its use could not be depleted by judgments in actions of the kind sued upon. At page 253 the court said: "If the funds of these institutions are to be diverted from their intended beneficent purposes by law suits and judgments for damages for negligent or malicious servants, their usefulness—indeed their existence—will soon be a thing of the past."

Liability of Public Institutions for Acts of an Inmate.

Leavell v. Western Kentucky Asylum for the Insane, 122 Ky. 213, 91 S. W. 671

The alleged cause of action was based upon these facts: that while plaintiff was employed by defendant to wash and iron clothing in its laundry, her hand was mangled between the rollers of an ironing machine; that the machine had been set in motion by a lunatic who was allowed to work in the laundry, and that this lunatic had been permitted to work in the laundry by reason of the gross negligence of the defendant. The lower court entered a judgment dismissing plaintiff's case, which judgment was affirmed by the Kentucky Court of Appeals.

Thus, the question presented upon the appeal was whether the asylum was to be held liable for the tortuous act of a lunatic who had been committed to its custody.

Now, the defendant was an eleemosynary institution which had been created by the state, and which was maintained at the state's expense. The court used this language at page 215: "Such institutions are mere instrumentalities of the State government brought into being to aid in the performance of governmental duty, hence the rule of respondeat superior does not apply to them. Appellee (defendant) cannot therefore be made to respond in damages for a personal injury inflicted upon another by its servant, or a lunatic in its charge, though such injury results from negligence or malicious act on the part of such servant or lunatic."

Liability of Railway Hospital.

Illinois Central Railway Co. v. Buchanan, 126 Ky. 288

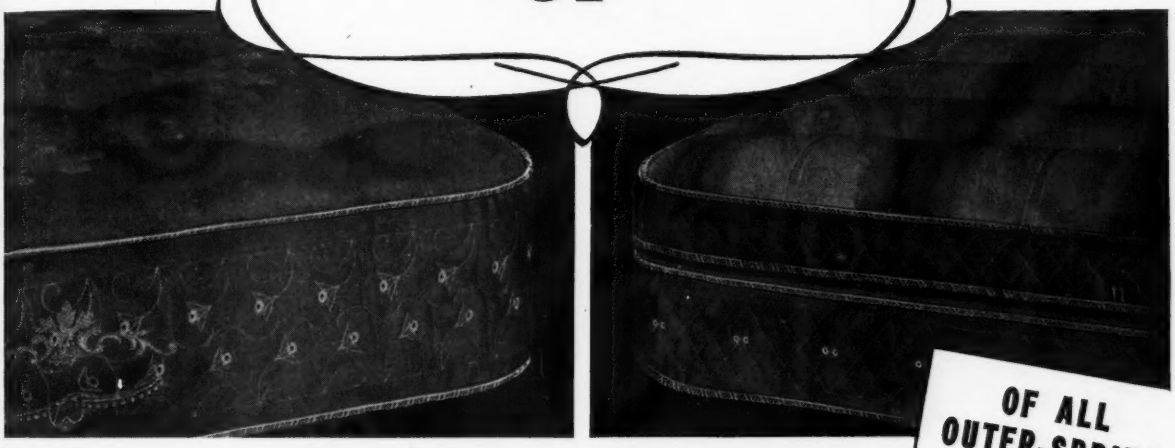
Plaintiff Buchanan brought an action against the company to recover damages for the alleged unskillful treatment that he received at the hands of certain surgeons and attendants in a hospital operated by the railway. The defendant company answered, setting up that the hospital was a corporation which was independent of the railway, and that the railway was not responsible for the acts of those who were in charge of the hospital. No profit was derived from operating the hospital; it was supported by monthly contributions of the employees. There was a verdict rendered in favor of plaintiff. Upon an appeal, the judgment of the lower court was reversed. The case under consideration arises on a petition for a rehearing. Here, the court overruled its former opinion, and held in favor of the plaintiff.

The court was of opinion that the railway could not be held liable for the negligence of its physicians and surgeons, but that it might be held liable for failing to exercise reasonable care in selecting them. This issue, whether the directors of the hospital had exercised due care in selecting the physicians, was to be presented upon a new trial.

INNER-SPRING
— THE CONVENTIONAL TYPE, WITH SPRING UNIT BUILT INSIDE. CUSTOM-BUILT TO SPECIFICATIONS.

Choose either Type

OUTER-SPRING
— THE EASY-TO-HANDLE TYPE, WITH SPRING UNIT AND PADDING IN TWO SEPARATE LAYERS.



—but let this FACT guide your choosing . . . . . .

There are 3,000 bedding manufacturers who share the right of making both types of modern mattresses . . . inner-spring and outer-spring. Many of them do make *both* types. Yet, nine out of ten outer-spring mattresses in use are Spring-Air!

Why?

Because the records made by all competing spring units in this direct, out-in-the-open comparison prove the unquestioned superiority of Spring-Air's guaranteed Karr Spring Construction!

Important as it is that the vital spring element be *right* in an outer-spring mattress, it is even more important that it be right in the inner-spring type where the spring unit is buried inside, hidden from inspection.

Be sure to get the guaranteed Karr Unit no matter which type of mattress you buy. Then you will be following the example of the expert buyers in thousands of hospitals and hotels who demand all the comfort, all the endurance they can get for their money. Every Spring-Air Mattress—in either type—has the guaranteed Karr Spring Construction! The record made by the guaranteed Karr Spring Construction in the outer-spring type of mattress proves that it is also the *right* construction for the inner-spring type.

OF ALL OUTER-SPRING MATTRESSES IN USE

90%

ARE

Spring-Air

TRADE MARK REG. U.S. & CAN. PAT. OFF.

WRITE FOR KARR WHITE TAG SLEEP UNIT 20 LITERATURE

SPRING-AIR

General Offices: **HOLLAND, MICHIGAN**

Canadian Offices: SPRING-AIR, 41 Spruce St., Toronto, Ont.

Spring-Air product standards are specified and, through inspection, maintained by the licensor, Charles Karr Company, Holland, Michigan, manufacturer of the spring elements used in completed Spring-Air products.

MILWAUKEE COUNTY HOSPITAL and hundreds of other renowned institutions throughout the United States and Canada use and endorse Spring-Air. That's natural, — because experts invariably buy what experts build.

46 FACTORIES IN U. S. AND CANADA

Liability of a University for Negligence in Connection With the Operation of an Infirmary.

University of Louisville v. Hammock, 127 Ky. 564

The plaintiff Hammock took a judgment for $1,000 against the university for injuries that she received while she was a patient in its infirmary as a result of an assault upon her by a demented patient who had been permitted to escape from his room. The judgment of the lower court was affirmed.

The principal defence presented was that defendant was a charitable corporation and exempt from liability for the negligent acts of its agents and servants. It was decided that this defence could not prevail, since the infirmary was operated in connection with the University, and largely operated for profit. Some few non-paying patients were received, but in the main, the patients were paying patients. Under these facts the court was constrained to hold that the infirmary was not a charitable institution. The university failed to prove that it was operating an essentially charitable hospital.

Liability for Death of an Inmate.

Ketterer's Admr. v. State Board of Control, 131 Ky. 287, 15 S. W. 200

This was an action in which damages were sought for wrongfully causing the death of an insane person who had been committed to the Eastern Kentucky Lunatic Asylum. The action was also directed against the superintendent of the asylum. The lower court dismissed the plaintiff's petition. This judgment of dismissal was affirmed upon this appeal.

The Court of Appeals said, p. 291: "The policy of the law in this State is to the effect that neither the State nor its officials, such as are sued herein, are liable for the wrongdoing of one acting under them who, by his negligence, causes an injury to be inflicted upon another. All the authorities relieve the State and such officials from responsibility in such cases and place the responsibility upon those persons who commit the acts which are the direct cause of the injury."

In absolving the superintendent of liability for the negligent acts of his subordinates the court said: "The principle 'respondeat superior' does not apply to public officers such as are sued herein, but only applies to individuals and corporations who employ servants in the furtherance of their private business." Again: "The under officers appointed by the board of control and Redwine did not act, in the performance of their duties, as the servants of or for the benefit of the board and Redwine, but were supposed to act for the good of the public in the furtherance of a charity, and therefore the board and Redwine are not responsible for their acts."

Liability of Charitable Hospitals for Wrongful Death of Patient.

Cook, Admr. v. John N. Norton Memorial Infirmary, 180 Ky. 331, 202 S. W. 874

This action was brought to recover damages for the death of plaintiff's wife alleged to have resulted from the negligence of defendant Infirmary. A judgment of dismissal was entered by the lower court, and upon the appeal, this judgment was affirmed.

It was alleged that the deceased had fallen from a window after she had been operated upon. The pleadings of defendant set up its organization as a purely charitable institution.

At page 333 of the opinion appears this language: "An examination of the authorities has convinced us that a purely charitable institution, such as defendant's hospital is described in the pleadings to be, is not amenable to its patients, although paid ones, for any damages which they may have sustained growing out of the alleged negligence, although such negligence might consist in the violation by the hospital of some duty imposed either by an express or an implied contract."

Liability of Charitable Hospital for Injury to an Employee.

Emery v. Jewish Hospital Association, 193 Ky. 400, 236 S. W. 577

Plaintiff sued for damages for the loss of a toe, having suffered injury while operating an elevator in the defendant hospital. Defendant answered, pleading that it was a charitable institution. In the lower court plaintiff's petition was dismissed. Upon the appeal, this judgment of dismissal was affirmed.

The court held that since defendant was a charitable hospital association, it would not be liable to respond in damages to **any person,** patient or stranger to the charity, for an injury resulting from the negligence of an employee. The court rested this exemption from liability upon the same ground as that of a governmental charity namely, that the doctrine of respondeat superior does not apply to situations wherein recovery of damages is sought because of the negligence of an employee, or of a subordinate officer.

Oxygen Says:

"During the past few years I have become an increasingly important factor to the Medical Profession. I am now being used preoperatively, postoperatively, in pneumonia, asthma, chronic heart conditions, etc. *BUT, to do my best work therapeutically,* I must be administered immediately following diagnosis, and continued until I have completed my task."

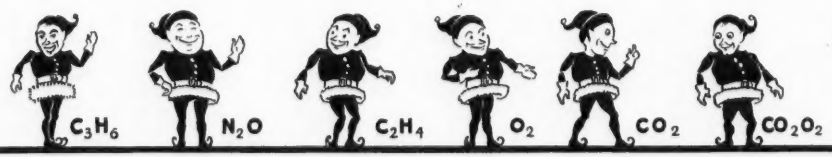
One of the most effective means for the administration of Oxygen in prolonged cases is the Nasal Catheter method — used and recommended by Doctors who have made a study of the value of Oxygen therapy.

Our PURITAN NASAL CATHETER OUTFIT, shown above, is efficient, economical, portable, and durable. We have installed this equipment in many of the leading Hospitals over the entire country. We call your particular attention to the pressure-reducing regulator with which this unit is equipped, which is of the highest quality. A high-pressure gauge shows contents of cylinder, and an accurate working-pressure gauge registers flow in litres per minute, with positive control.

PURITAN NASAL CATHETER OUTFITS
LEADING MAKES OF OXYGEN TENTS
BEDSIDE INHALATION UNITS

For Sale or Rental at all of our Locations

PURITAN MAID
TRADE MARK REG.



CYCLOPROPANE
NITROUS OXID
ETHYLENE
OXYGEN
CARBON DIOXID
PERCENTAGE MIXTURES OF CARBON DIOXID AND OXYGEN

All Types of Anesthetic Gas Machines — Resuscitators and Inhalators — Wilson Soda Lime

PURITAN COMPRESSED GAS CORPORATION

KANSAS CITY ST. LOUIS ST. PAUL DETROIT CINCINNATI CHICAGO CAMBRIDGE BALTIMORE

Liability for Wrongful Disposal of Corpse.

University of Louisville v. Metcalfe, 216 Ky. 339, 287 S. W. 945

The plaintiff, Mrs. Metcalfe, sued the university and the Western State Hospital for damages for wrongfully disposing of the corpse of her husband. There was a judgment of $5,000 entered in favor of plaintiff. This judgment was reversed.

A Kentucky statute required hospital superintendents to notify the relatives of a deceased, and to hold the body for three days. After three days the body, if unclaimed, could be sent to a medical school. It was to be held for thirty days in the medical school, after which time it could be examined and dissected. The evidence showed that the body in this case was not held three days by the superintendent of the Western State Hospital, and that the University of Louisville began dissecting before expiration of the period named in the statute.

It was held that the state hospital, in disposing of unclaimed bodies, was performing a governmental function, and so, would not be liable for negligence in its disposition of a corpse. The University of Louisville had not been properly made a party to this action, since it was sued out of the county in which it was incorporated. Consequently, the judgment as to it was not good, the court not having jurisdiction of the University as a party defendant in this case.

Liability of Charitable Hospital for Acts of Surgeon.

Pikeville Methodist Hospital v. Donahoo, 221 Ky. 538, 299 S. W. 159

Plaintiff Donahoo sued the hospital for the negligence of a surgeon connected with defendant in placing a heating pad upon the plaintiff's broken arm, thereby burning the arm so severely as to require amputation.

The hospital and the surgeon answered alleging that it was necessary to amputate plaintiff's arm because of his own carelessness in failing to follow the surgeon's instruction. The hospital did not set up in any pleading the fact that it was a charitable corporation. Upon the trial plaintiff took a judgment of $5,000.

The court first held that since the defendant had not pleaded its organization as a charitable hospital, it could not take advantage of the rule exempting such hospitals from the consequences of their negligence. However, the plaintiff failed to show that the surgeon in this case, at the time of the alleged negligence, was acting for the hospital. Therefore his negligence could not be charged to the hospital. In fact, the evidence was clear on the point that the surgeon who cared for plaintiff was not in the employ of the hospital.

Recent Cases

Liability of a Charitable Hospital for the Negligence of an Employee.

Messina v. Societe Francaise De Bienfaisance Et D'Assistance Mutuelle De La Nouvelle Orleans, (La.), 170 So. 801

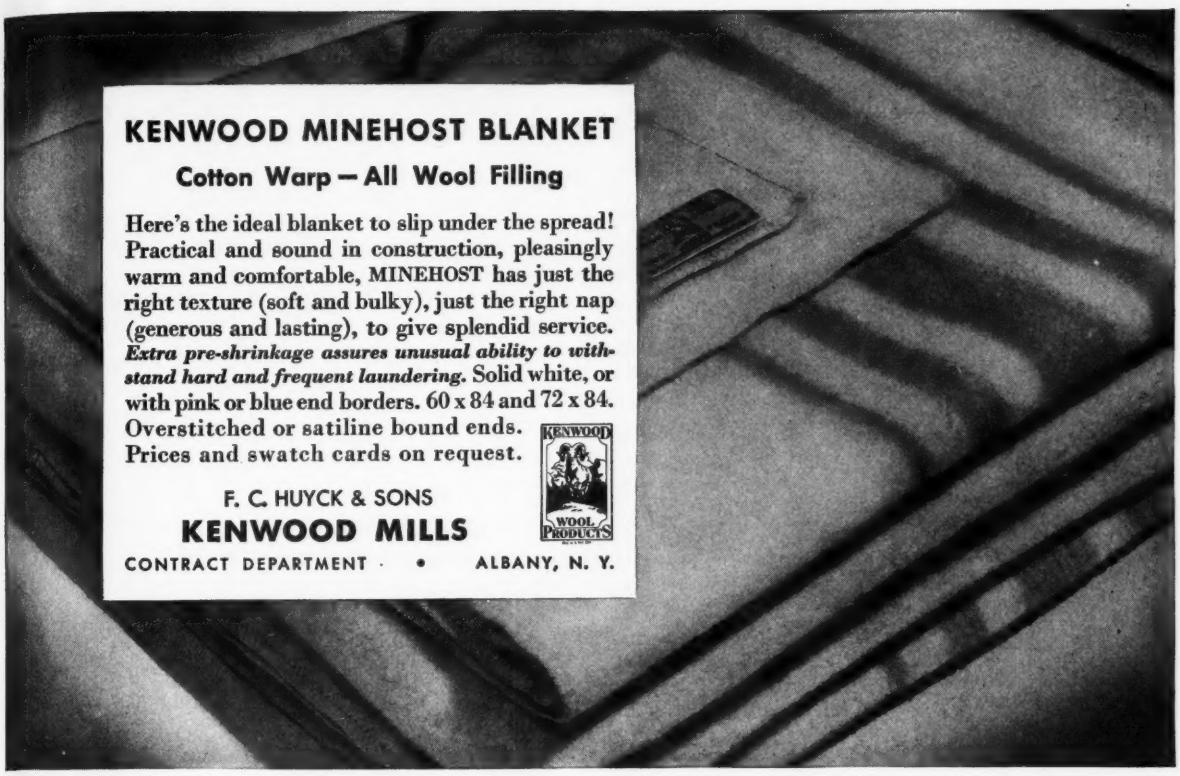
The plaintiff, Messina, took a judgment on the trial which was reversed upon this appeal. The hospital and its insurer prosecuted the appeal.

Plaintiff's cause of action was founded upon the alleged negligence of an externe connected with the hospital, in his administration of hypodermatoclysis. The plaintiff was a pay patient, and claimed to have been burned about the legs as a result of the alleged negligence of the externe in administering a hypodermatoclysis.

The court considered the liability of hospitals generally, and recognized that, for the purpose of determining the question of liability, hospitals had been divided into three classes. These classes are: public, private eleemosynary, and strictly private. Hospitals of the first class, being governmental agencies, were not to be held liable. Institutions of the second class are exempted from liability upon various grounds—public policy, the trust fund doctrine, and upon the ground that the rule of respondeat superior has no application to hospitals of this class. Private hospitals, on the other hand, are liable for the negligence of their employees.

It was further considered by the court to be unnecessary to determine what class of institution defendant belonged to, and the question of liability was dealt with directly. In its inquiry as to liability, after commenting upon the evidence, the court was of opinion that there was not sufficient evidence of negligence to carry the case to the jury. The evidence showed that the hypodermatoclysis had been administered by the externe, a fourth year medical student, under what might be called approved technique.

The court was of the opinion that the hospital, and its insurer could not be held liable for errors of professional judgment of the externe, especially where the evidence showed that hospital had exercised due care in employing him. Liability of the hospital was denied upon another ground—that since the hypodermatoclysis had



KENWOOD MINEHOST BLANKET

Cotton Warp — All Wool Filling

Here's the ideal blanket to slip under the spread! Practical and sound in construction, pleasingly warm and comfortable, MINEHOST has just the right texture (soft and bulky), just the right nap (generous and lasting), to give splendid service. ***Extra pre-shrinkage assures unusual ability to withstand hard and frequent laundering.*** Solid white, or with pink or blue end borders. 60 x 84 and 72 x 84. Overstitched or satiline bound ends. Prices and swatch cards on request.

KENWOOD WOOL PRODUCTS

F. C. HUYCK & SONS

KENWOOD MILLS

CONTRACT DEPARTMENT • ALBANY, N. Y.

Plan NOW *for* HOSPITAL DAY

Use our Publicity Service to promote a bigger National Hospital Day (May 12th). Here is a plan so well rounded and complete that it ideally meets the needs of both large and small hospitals.

Our Service Consists of:

Beautifully designed colored posters, postcard announcements, newspaper mats, movie film trailers, birth certificates, gummed stickers for your mail and the popular folder rack with complete service of six folders, as illustrated.

***Hundreds of Hospitals have found* the folder rack service especially effective in distributing appropriate literature to visitors. The folders included are conservative, non-technical, easily read and appropriately illustrated. The rack is of steel, finished in a rich brown color.**

Send for details.

PHYSICIANS' RECORD CO.

The largest Publishers of Hospital and Medical Records

161 W. Harrison St. 13 Chicago, Ill.

We Have a STANDARDIZED FORM for Every Hospital Purpose

THE MARK OUTLASTS YOUR LINEN

For less than ¼c a piece, you can permanently mark all your linens, towels, blankets, etc. The impression is dyed into the cloth, never to wash or wear out. *Send for Catalog and Sample Impression Slip.*

APPLEGATE'S INDELIBLE INK

Silver base, will never wash out, and lasts full life of any fabric.

XANNO INDELIBLE INK

Lasts much longer than other inks NOT requiring heat to set.

Ask about our low-priced Linen Markers.

APPLEGATE'S INKS & MARKERS

APPLEGATE CHEMICAL CO.

5630 HARPER AVE. CHICAGO, ILL.

been administered by the externe at the request of the patient's own surgeon, the externe, while administering such treatment, became an employee of the surgeon, and not of the hospital.

This case, and another earlier Louisiana decision, are of the few decisions basing non-liability in whole or in part, upon the ground that the employee, while administering treatment at the request of the patient's own physician, becomes the employee of the physician. A majority of the courts are content to place exemption from liability upon the grounds either of the trust fund doctrine, public policy, or non-application of the doctrine of respondeat superior to hospitals of this class.

Validity of Bequest to a Hospital.

Frazier v. Merchants National Bank of Salem, (Mass.), 5 N. E. (2) 550

John H. Frazier gave the remainder interest in his estate to the bank, as trustee, with a direction that the bank allow the income to accumulate and be added to the principal until the whole should amount to one million dollars. A further direction to the trustee bank was that it hold the one million dollars as a permanent trust for the benefit of the Salem Hospital, the income to be paid to the hospital semi-annually.

The questions presented by this appeal are whether the trust violates the rule against perpetuities, and whether it violates any principle of public policy.

The Massachusetts court was of opinion that the beneficial interest of the hospital vested in it immediately, and that therefore the trust could not be said to violate the rule against perpetuities. Further, the court could find nothing in the trust provisions which would be contrary to the public policy of the state.

Liability of a Charitable Hospital for an Unauthorized Autopsy.

McPosey v. Sisters of the Sorrowful Mother, (Okla.), 57 P. (2) 617

Plaintiff sued the defendant corporation and certain individuals for performing an unauthorized autopsy upon the body of his wife. Defendant filed a demurrer to the petition of the plaintiff, and the demurrer being sustained, plaintiff did not plead further. This resulted in a judgment in favor of the defendant. Upon this appeal of the plaintiff the judgment of the lower court was reversed in favor of plaintiff.

The court said: "The wrongful dissection of a dead body is regarded as a willful and intentional wrong against the person entitled to the possession and control of the body for burial, and a recovery may be had for the mental anguish resulting from such a mutilation."

A Court Decision of Interest to Hospitals

A Court ruling of interest to hospitals was made by Judge Klein of Orphans' Court, Philadelphia. One of the Pennsylvania hospitals had been bequeathed a sum of money insufficient to endow a private room in this institution, and the bequest was contested by the heirs to the estate, on the ground that the amount bequeathed was insufficient to accomplish the purpose the donor intended.

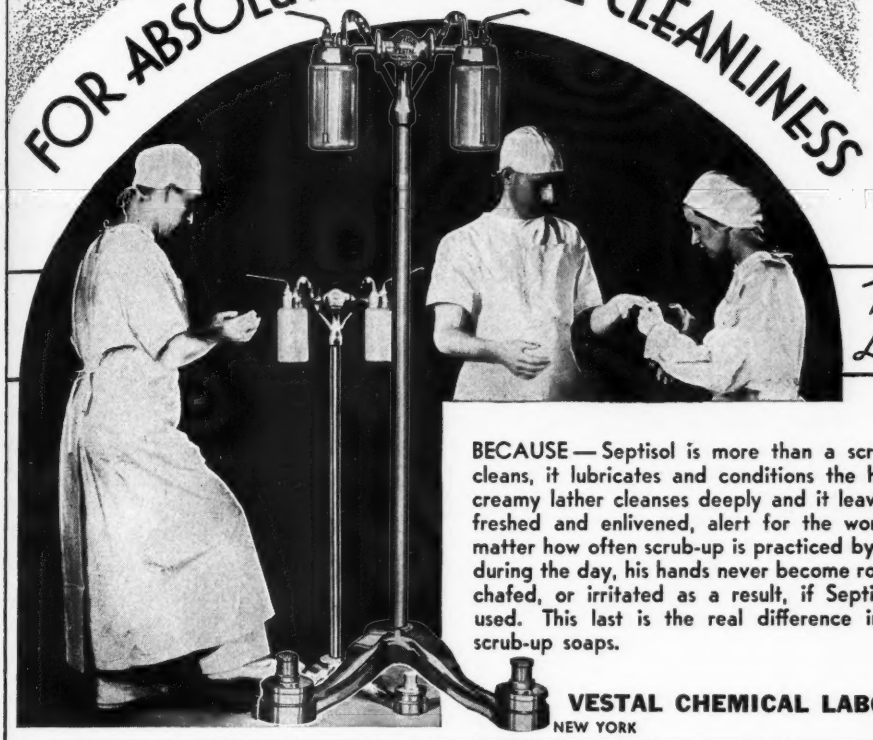
The Court ruled that the hospital could receive the money and add a sufficient sum to it from other sources to accomplish the purposes of the bequest. In ruling the Court said, "It is contrary to the trend of our decisions to hold that a charitable bequest failed merely because the estate of the testatrix was insufficient to accomplish her purpose in full."

CORRECTIONS

The February issue of *HOSPITALS* carried a personal note to the effect that Miss A. C. McKeague has resigned as superintendent of the Williamsport Hospital, Williamsport, Pennsylvania. The information contained in this note was in error and *HOSPITALS* regrets very much the annoyance that the publication of the notice occasioned. Miss A. C. McKeague is the present superintendent of the Williamsport Hospital.

Rose L. Mapes was appointed acting superintendent of the Montclair Community Hospital, Montclair, New Jersey, and not superintendent as noted in the February issue of *HOSPITALS*.

FOR ABSOLUTE SURGICAL CLEANLINESS



VESTAL PROVIDES THE ULTIMATE. Septisol Dispensers, with their many exclusive features, are approved by the American College of Surgeons. Septisol Soap has won the acclaim of hospitals and surgeons everywhere.

The Standard in Leading Hospitals

BECAUSE — Septisol is more than a scrub-up soap — as it cleans, it lubricates and conditions the hands. Its smooth, creamy lather cleanses deeply and it leaves the hands refreshed and enlivened, alert for the work ahead. No matter how often scrub-up is practiced by the surgeon during the day, his hands never become roughened, chafed, or irritated as a result, if Septisol is used. This last is the real difference in scrub-up soaps.

VESTAL CHEMICAL LABORATORIES, INC.
NEW YORK ST. LOUIS

THE EIGHT-HOUR SCHEDULE

REVISION OF THE CURRICULUM

ACCREDITATION OF NURSING SCHOOLS

GRADUATE STAFF NURSING

These and other topics of vital interest to hospital administrators as well as to nurses are discussed in the official magazine

of the

AMERICAN NURSES' ASSOCIATION

and the

NATIONAL LEAGUE OF NURSING EDUCATION

★

The American Journal of Nursing
50 West 50th Street **New York City**

$3.00 for 1 year; $3.50 in Canada

FOR

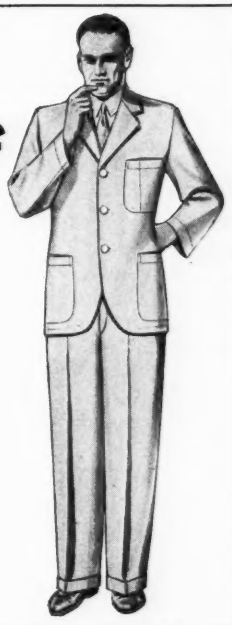
Real Service

USE

Williams' Standard Interns' Suits

GOWNS
NURSES' UNIFORMS
TRAINING SCHOOL OUTFITS
CAPES

SEND FOR CATALOGUE HI



C. D. Williams & Company

Designers and manufacturers since 1876

Member of the Hospital Exhibitors' Ass'n

246 South 11th Street **Philadelphia, Pa.**

News Notes

Leon A. Bondi, superintendent of the Galesburg Cottage Hospital, Galesburg, Illinois, and Gladys Krase, superintendent of nurses of that institution, were married on January 14. Bertha Mann, formerly assistant superintendent of the Evanston Hospital, Evanston, Illinois, has been appointed superintendent of nurses to succeed Mrs. Bondi.

Stella Burkholder has been appointed superintendent of the Bluffton Community Hospital, Bluffton, Ohio. Miss Burkholder has been serving as acting superintendent of the institution following the resignation of the superintendent, Mrs. Glen Miller. Helen Maxwell has been appointed assistant superintendent.

Dr. Joseph L. Eagle has been appointed medical director of the Northern Michigan Tuberculosis Sanatorium, Gaylord, Michigan. The sanatorium is under construction and will be opened about July 1.

Dr. J. B. Copeland, superintendent of Robert B. Green Memorial Hospital, San Antonio, Texas, has resigned to enter private practice in San Antonio. Dr. Frank Paschal has been appointed to succeed Dr. Copeland. This change became effective February 1, 1937.

Martha McKay, R. N., superintendent of the Annie M. Warner County Hospital, Gettysburg, Pennsylvania, for more than fourteen years, has resigned.

Charlotte W. Ager, formerly superintendent of the Columbia Hospital, Columbia, succeeds Elizabeth Guthrie as superintendent of the Armstrong County Hospital, Kittanning, Pennsylvania.

Frank Schmidt, superintendent of Franklin Hospital, San Francisco, was elected president of the San Francisco Hospital Conference at the annual meeting. Other officers of the Conference are Mrs. H. N. Snow, superintendent of Children's Hospital, vice-president, and V. W. Olney, superintendent of St. Francis Hospital, treasurer.

Flora G. Smith, superintendent of the Jay County Hospital, Portland, Indiana, for the past two years, has resigned. Anna Yeager, the assistant superintendent, has been appointed to succeed Miss Smith.

Margaret Faith has been appointed superintendent of the Homeopathic Hospital, West Chester, Pennsylvania. She succeeds Mrs. Florence C. Smith who served as superintendent of this institution for fifteen years and who recently resigned to move to California.

Lillian H. Carson, superintendent of Women's Homeopathic Hospital, Philadelphia, Pennsylvania, has resigned after twenty years' service as superintendent of that institution.

Charles E. Findlay has resigned the superintendency of the Butterworth Hospital, Grand Rapids, Michigan, and has accepted the superintendency of the Wyandotte General Hospital, Wyandotte, Michigan.

Miss Francis Yon has been appointed superintendent of Tarpon Springs Hospital succeeding Miss Hamali King, who has resigned.

Miss Hedwig Harke, who has been acting superintendent of Ossining hospital since last November, was appointed superintendent of the Annual meeting of the Board of Trustees February 2.

Miss Alcinda Johnson, R.N., formerly surgical supervisor at John C. Proctor Hospital, has been appointed Superintendent of that institution to succeed Dr. James L. Smith, resigned.

Dr. Arnold A. Karan, assistant director of The Jewish Hospital, has resigned from this position to accept the superintendency of the Workmen's Circle Sanatorium at Liberty, New York. Dr. Jacob Prager, a graduate of the house staff of The Jewish Hospital, and a resident physician at the Kings County Hospital, has been appointed to succeed Dr. Karan.

Clarksville, Arkansas—The city will construct a community hospital to cost approximately $75,000.00. The project will be financed by the sale of city bonds under a special tax ordinance for 55 per cent of the amount, and the WPA will grant the remainder.

Wilmington, Delaware—St. Francis Hospital, Wilmington, Delaware, is completing a $200,000

QUALITY

Manufacturers

INSTITUTIONAL FURNITURE

Complete Layouts and Quotations Furnished Entirely without Obligation

JAMES.L.ANGLE COMPANY

LUDINGTON - - - - MICHIGAN

A Brisk Beginning Sets the Keynote for 1937

New Hospitals Are Being Built —Existing Institutions Are Being Enlarged—Schools of Nursing Are Being Re-Opened — The Whole Trend Is One of Expansion.

This Means—More Positions for Nurses.

Eager for Advancement—Alert to the Advantages of Association with a Professional Bureau —Nurses Are Registering Now for Fall Appointments.

This Means — Well-Qualified Nurses Available for All Positions.

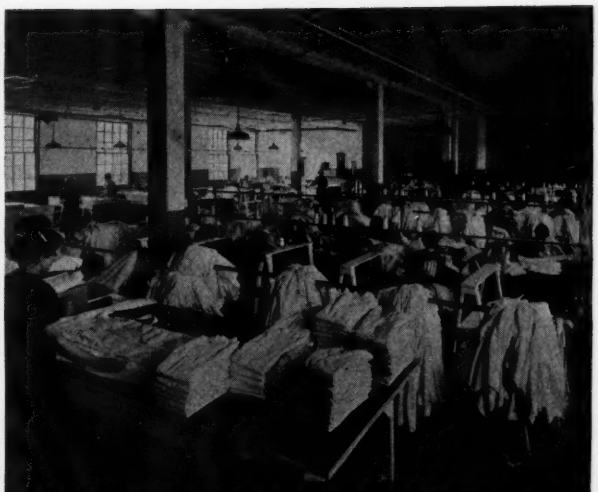
Write Today

NURSE PLACEMENT SERVICE

Room 513, 8 South Michigan Avenue

CHICAGO, ILLINOIS

A Coast to Coast Service to Hospitals and Nurses



WE HAD TO CREATE A GARMENT FACTORY

To Completely Satisfy all Hospital Needs

YEARS ago, we learned this truth: Making garments for hospital service is a *fine art*, demanding intensive specialization. Ordinary, standardized, factory-run garments will not do.

We learned how *important* seemingly unimportant details can be—how vitally necessary it is, for example, that *operating gowns* be the *absolute ultimate* in comfort and freedom for the wearer; devoid of minor annoyances such as tight shoulders or ill-fitting sleeves . . . tremendous trifles that might spell the difference between *successful* or unsuccessful operations.

We learned that patients' gowns had to be especially designed to meet the needs of the wearer and the requirements of hospitalization. *Comfort* for the patient is obviously a paramount consideration—to promote ease and relaxation. Easy accessability of the patient's person for needed attentions with minimum disturbance to the patient, is equally important.

In addition to these considerations is the fact that all hospital garments, more than any other garments made, must withstand repeated laundering and hard usage and yet retain their professional smartness over an extended period of time.

To provide hospitals with garments having all the necessary elements; to furnish the kind of garments we know hospitals should have — we had to start our own garment factory where we could have complete and constant control of every process, from the initial design to the final inspection of the finished garment.

In their satisfactory service White Knight Garments demonstrate the value of a factory designed for and devoted exclusively to the manufacture of Hospital Garments.

WILL ROSS, Inc.

WHOLESALE HOSPITAL SUPPLIES · Milwaukee, Wis.

annex, which will be dedicated in May. When finished the annex will answer the needs of enlarged facilities, due to increased population and demands in Wilmington and its trade area.

The original hospital was constructed in 1923. The new annex is of Romanesque design and will be 122 feet long and 42 feet wide. The first floor will include clinics, laboratories, and doctors' quarters, together with a large accident ward completely equipped for surgical and medical emergencies, with a receiving ward adjacent.

The laboratory department will include a blood chemistry room, general laboratory, sterilizing room, office, and a room for basal metabolism tests.

The doctors' quarters will consist of three large bedrooms, two baths, and a dining room. On the ground floor a lecture room will be provided seating about three hundred persons.

The second floor will contain a modern maternity department of twenty-two beds, a plate glass enclosed nursery, milk formula room, sterilizing and linen rooms, utility room, a complete isolation unit, and a dietary department with the latest modern equipment.

Among the new features which the building will contain will be the installation of a hydro-electric emergency current supply outfit. This unit takes care of the lighting in the delivery and operating rooms, elevators, corridors, fire escape. It is designed to insure a never-failing source of light, in case the city electric current is temporarily out of order.

A unique call system will also be installed. This device is of the latest style and one of the main features will be that should the signal plug in the room of a patient become detached, an immediate call will be made to the attention of an attendant or nurse, indicating that something is wrong in the room.

Jacksonville, Florida—Frank E. Jennings, Chairman of the Duval County Welfare Board, announces plans for the construction of a six-story addition to the Duval County Hospital. The addition would add two hundred beds to its present capacity.

Cordele, Georgia—W. Elliott Dunwoody, architect, has been authorized to prepare plans and estimates of a 25 bed municipal hospital.

Quitman, Georgia—Bids were opened on February 9, for the construction of an annex to the New Brooks County Hospital. This hospital was opened to the public in November, 1936, and has been filled to capacity since that time, necessitating the new addition.

Peoria, Illinois—Work on the new $125,000 ward building at the Peoria State Hospital started on January 13. The building is the first of a new construction program for this institution. Other buildings included in the program are a $250,000 diagnostic hospital, a $75,000 addition to the employees' building, and a $50,000 boiler and power house.

Princeton, Illinois—The Perry Memorial Hospital is planning to construct an addition to cost $100,000.

Rock Island, Illinois—St. Anthony's Hospital has approved the plan submitted by Herman J. Gaul, Chicago architect, for a five-story addition to the present plant.

Indianapolis, Indiana—A new wing to be devoted to the hospitalization of colored patients will be added to the city hospital. It will be five stories in height and will cost $200,000 when completed. The WPA has made a grant of $86,850 for this purpose representing 45 per cent of the construction costs.

Terre Haute, Indiana—Under the terms of the will of the late Mary Alice Warren, the Union Hospital was bequeathed the sum of $20,000, the income to be used for hospital purposes.

Boston, Massachusetts—Plans for the construction of a new home for the nurses at Newton Hospital have been started. The home will cost $700,000 when completed and finished.

Boston, Massachusetts—The New England Baptist Hospital, Boston, Massachusetts, has under construction a new wing, of fireproof construction and six stories in height. It will add 100 beds consisting for the major part of moderate priced rooms, a large number of which have a porch upon which the beds may be rolled out without disturbing the patient.

Boston, Massachusetts—Under the terms of the will of William A. Sargent, a retired Brookline lawyer, $300,000 each was left to the Massachusetts General Hospital and to the New Englannd Deaconess Hospital in Boston. The gift to the Massachusetts General Hospital is to be used for free beds in the women's department of the hospital, under the name of the Margaret A. Sargent Memorial Fund.

Pittsfield, Massachusetts—The House of Mercy Hospital received a legacy of $25,000 from the

EXCLUSIVE things, those vitamins. So exclusive that there's only one way to capture and *keep* them, and that is to process and pack the tender, succulent vegetables within a few hours after they come fresh-picked from the field. Sexton Vegetables are full of the original flavor and nutriment, sealed right in the can, before they can escape. By selecting Sexton Vegetables, you not only have the assurance of full vitamin value, but the added assurance that you are getting the finest of the crop in the districts noted for their outstanding varieties. Containers chock full, too, and the size most economical for your use.

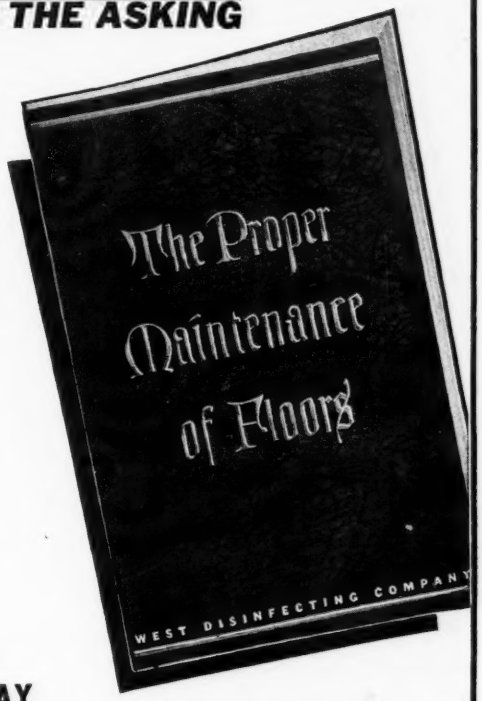
Sexton Specials offer outstanding values in foods prepared exclusively for those who feed many people each day.

JOHN SEXTON & CO.
Manufacturing Wholesale Grocers
America's Largest Distributors of No. 10 Canned Foods
CHICAGO BROOKLYN

© J. S. & Co., February, 1937

FREE!

FOR THE ASKING



AND IT MAY SAVE YOU HUNDREDS OF DOLLARS IN FLOOR MAINTENANCE COSTS

The following types of floors are included in this booklet:

- UNPAINTED WOOD
- LINOLEUM
- CEMENT, CONCRETE OR CORK
- RUBBER TILE OR RUBBEROID
- SOFT ASPHALT COMPOSITION OR SOFT MASTIC TILE
- MAGNESITE OR HARD MASTIC
- PAINTED OR VARNISHED SURFACE
- TERRAZZO
- MARBLE
- FAIENCE TILE
- SLATE OR QUARRY
- GARAGE FLOORS
- WASHROOM FLOORS
- CELLAR FLOORS
- GYMNASIUM, ARMORY OR DANCE FLOORS

WEST DISINFECTING COMPANY

DEPT. K, 42-16 BARN STREET, LONG ISLAND CITY, NEW YORK
Branches in 55 Principal Cities
LARGEST ORGANIZATION OF ITS KIND IN THE WORLD

estate of the late Albert N. Parlin of New Hampshire. The income is to be used to furnish free beds for patients unable to pay.

Benton Harbor, Michigan—The Benton Harbor Hospital Association have decided to build a $60,000 addition to Mercy Hospital.

Grand Haven, Michigan—Plans have been submitted for the construction of the new Hatton Hospital.

Saginaw, Michigan—All real estate and physical property and equipment of the former Woman's Hospital have been transferred to St. Luke's Hospital Association. The transfer was made in accordance with an agreement with St. Luke's when that association took over operation of the former Woman's Hospital.

Hibbing, Minnesota—A bill has been introduced in the Minnesota Legislature providing for the erection of a Municipal Hospital to cost $300,000. The money is to be provided by the WPA and bonds issued by the city in excess of present tax limitation.

Jackson, Mississippi—The late Richard Green, one of the foremost philanthropists in Mississippi, left his residuary estate, amounting to from $350,000 to $400,000, for the establishment of a free hospital for negroes in Jackson, Mississippi, or for the purpose of building wards for negro patients at some hospital already established, or some hospital to be established.

Rosedale, Mississippi—The new municipal hospital is practically completed, and will be dedicated and open for patients early in March.

Nevada, Missouri—The city voted to issue bonds in the sum of $50,000 to construct a city hospital. This amount will be supplemented with WPA funds.

St. Louis, Missouri—The city's new $3,000,000 Homer G. Phillips Hospital for Negroes was dedicated on Washington's Birthday, February 22. Secretary of the Interior Ickes was among the speakers. The hospital will have accommodations for six hundred patients.

St. Louis, Missouri—Construction is about to start on the $1,000,000 Malcolm A. Bliss psychopathic institute, which will be located just north of the present city hospital and will be connected with it by tunnels. It will provide accommodations for 185 patients.

Helena, Montana—The Fort Harrison Veterans Hospital closed temporarily because of damages due to earthquake, has been completely renovated, and was opened for the reception of patients on February 15.

Hastings, Nebraska—Bids were opened on January 19, by the Nebraska Board of Control for the construction of a 300-room hospital to replace the Hastings State Hospital. When completed the building will cost about $300,000.

Newark, New Jersey—The new combined wing for St. Barnabas, and for Women and Children's Hospitals is well along in construction and will be completed in July. It will cost one-half million dollars and will provide accommodations for an increased number of private and semi private patients.

Artesia, New Mexico—Plans have been completed to erect a $50,000 municipal hospital.

Gallup, New Mexico—This city is planning to construct a municipal hospital to cost in the neighborhood of $125,000. This hospital is to be financed by Federal funds and when completed it is to be leased by the Sisters of St. Mary's Hospital and operated as a municipal institution.

Hot Springs, New Mexico—The Carrie Tingley Hospital is completed. This is a crippled children's hospital, one of the finest of its kind in the United States, which Henry Toombs, architect for the Warm Springs Foundation in Georgia, designed.

Brooklyn, New York—Contract for the construction of a new building for the Holy Name Hospital to cost $280,000 has been awarded to the Chapman Kange Engineering Company. The plans were prepared by Crow, Lewis and Wick, architects.

Powers Lake, North Dakota—The Powers Lake Municipal hospital, under construction, and about two-thirds completed burned to the ground January 27. The hospital was of wood and tile construction.

Ada, Ohio—Plans have been completed for the construction of a ten-bed hospital and a university medical dispensary at the Ohio Northern University.

Columbus, Ohio—A nurses home, and a new research laboratory have been recommended for the Children's Hospital.

Millersburg, Ohio—The Joel Pomerene Memorial Hospital, the new Holmes County hospital, will be opened about May 1.

CLASSIFIED ADVERTISEMENTS

RATES: Eight cents a word. The minimum advertisement is 25 words at a cost of $2.00, including address or key number of 5 words. All answers to keyed advertisements will be forwarded. Classified advertising copy must be received at the office of *HOSPITALS*, 18 E. Division St., Chicago, Illinois, by the fifteenth of the month preceding issue.

THE FOLLOWING CLASS OF ADVERTISEMENTS WILL BE ACCEPTED:

POSITIONS WANTED.
POSITIONS WANTED THROUGH PLACEMENT BUREAUS.
POSITIONS OPEN.
POSITIONS OPEN THROUGH PLACEMENT BUREAUS.
SCHOOLS, SPECIAL INSTRUCTION, ETC.
FOR SALE.

Commercial announcements accepted at the same rate. Remittance must accompany classified advertisements.

CONSULTANTS

Charles S. Pitcher
Hospital and Institutional Consultant
1521 Spruce St.
Philadelphia, Pa.

POSITIONS WANTED

GRADUATE REGISTERED NURSE of large midwestern hospital with teaching and supervising experience of several years in hospitals of 25 to 200 beds. Address Box PI, HOSPITALS.

THE MEDICAL BUREAU

M. Burneice Larson, Director
Top Floor, Pittsfield Building
Chicago, Illinois

SOCIAL WORKER—A.B. and M.A. degrees; majors in social work and psychology; seven years' successful experience in medical and psychiatric social work. No. 412, Medical Bureau, Pittsfield Building, Chicago.

ADMINISTRATOR—Well qualified young man who has had six years' experience as assistant superintendent of university hospital is available; B.S. degree, state university; four years' experience in the business world before entering hospital field. No. 413, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—Qualified to take charge of large school; A.B., M.A. degrees; graduate of large teaching hospital; eight years, superintendent of nurses and principal school of nurses, 600 bed hospital; splendid background; best of training. No. 414, Medical Bureau, Pittsfield Building, Chicago.

DIETITIAN—B.S., state college; course in hospital dietetics, teaching hospital where she remained for two years as assistant; four years, administrative and therapeutic dietitian, 150-bed hospital. No. 415, Medical Bureau, Pittsfield Building, Chicago.

INTERSTATE PHYSICIANS & HOSPITAL BUREAU

Mary E. Surbray, R.N., Director
332 Bulkley Building
Cleveland, Ohio

DIRECTRESS OF NURSES: College graduate. M. A. Columbia University. Graduate well known school. Taught school before entering school of nursing. Number of years' experience. Has pleasing personality, efficient in her department. Open for appointment.

ANAESTHETIST: Graduate nurse, post-graduate Lakeside School of Anaesthesia. Graduate mid-western hospital. Eight years' experience; seven years present position. Desires to make a change.

POSITIONS WANTED—(Continued)

NEW YORK MEDICAL EXCHANGE (Agency)

Patricia Edgerly, Director
489 Fifth Avenue
New York City

RADIOLOGIST—American, Christian, trained at New York Post Graduate, wishes eastern location.

HOSPITAL SUPERINTENDENTS—(A) Graduate nurse, 41, Boston City Hospital graduate, 13 years' experience as superintendent of fine hospital. (B) Graduate nurse, has attended Institute of American Hospital Association, was instructress, then superintendent of nurses, after 9 years feels that she could take charge of small hospital. (C) Graduate nurse, Fellow of American College of Hospital Administrators, excellent buyer, 10 years' experience as superintendent.

ASSISTANT SUPERINTENDENT—Woman layman, has attended Institute of Hospital Administrators, has been bookkeeper and business manager in absence of superintendent.

DIRECTOR OF EDUCATIONAL DEPARTMENT or Superintendent of Nurses, 28, Bellevue graduate, B.S. degree from Columbia, excellent experience.

SUPERINTENDENT OF NURSES, or Science Instructress, or Superintendent of small hospital, graduate of fine eastern training school, prefers East, South or Midwest.

INSTRUCTRESS OR SUPERVISOR, 33, has been night superintendent and assistant to superintendent of nurses and practical instructress for 5 years.

SCIENCE INSTRUCTOR, head nurse or operating rom, Yale graduate.

SUPERINTENDENT OF NURSES or Science Instructress, B.A. degree, 10 years' experience as superintendent of nurses.

POSITIONS OPEN

ZINSER PERSONNEL SERVICE

1551 Marquette Building
Chicago, Illinois

GENERAL DUTY NURSES: Openings in all states. Give location and size of hospital preference in your reply.

SUPERVISORS: Openings for registered nurses with post graduate work or experience in (a) surgery, (b) obstetrics, (c) pediatrics, (d) psychiatric nursing, (e) medical nursing, (f) nursing supervision.

REGISTERED NURSES: (a) With laboratory and X-ray experience, (b) with stenographic ability, (c) able to give anesthetics, (d) with university education and teaching ability.

EXECUTIVES: (a) Superintendent in a small hospital, (b) assistant superintendent in a medium sized hospital, (c) superintendent of nurses.

(Continued on page 135)